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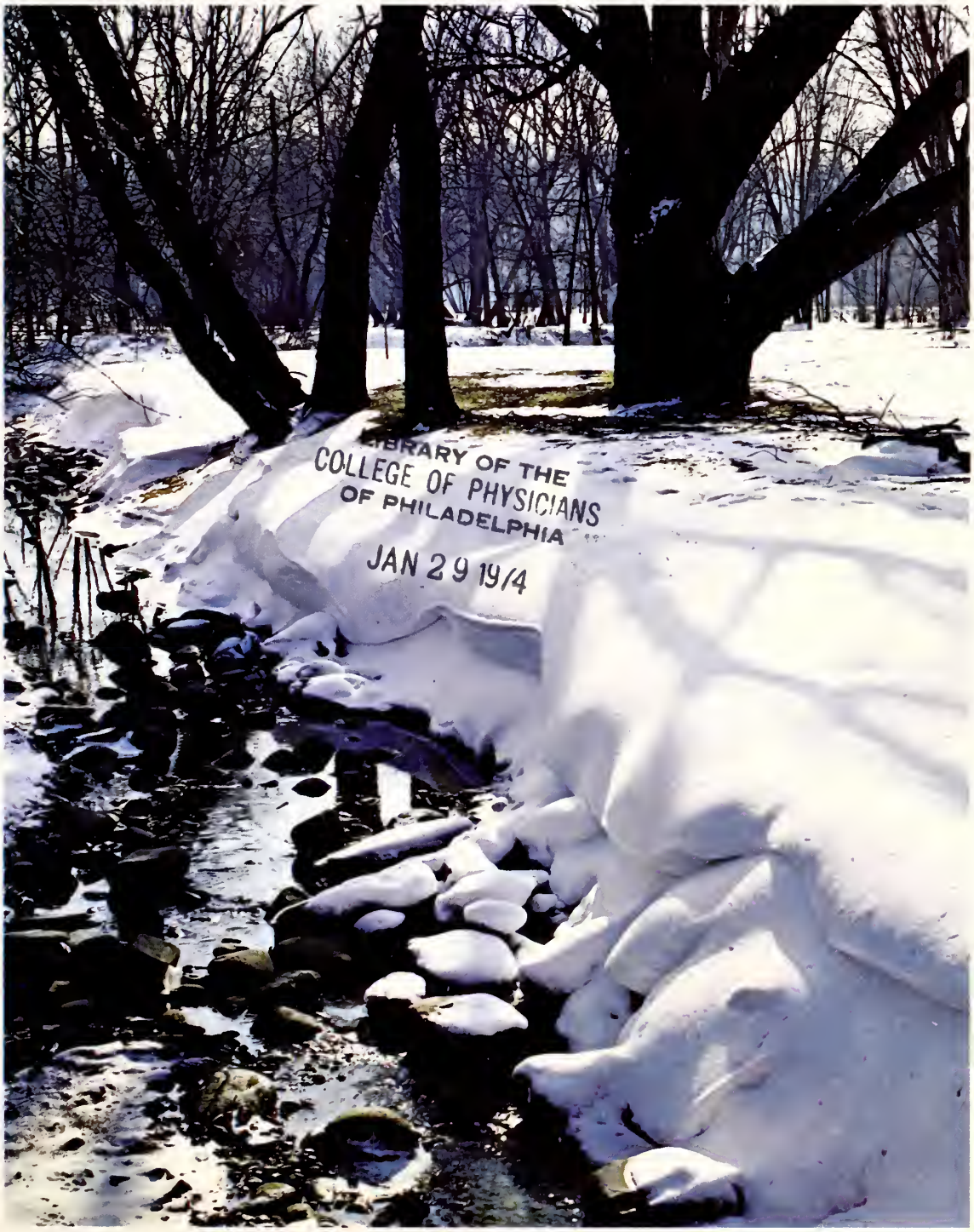
MICHIGAN/MEDICINE

OFFICIAL JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY

VOLUME 73, NUMBER 2 JANUARY, 1974



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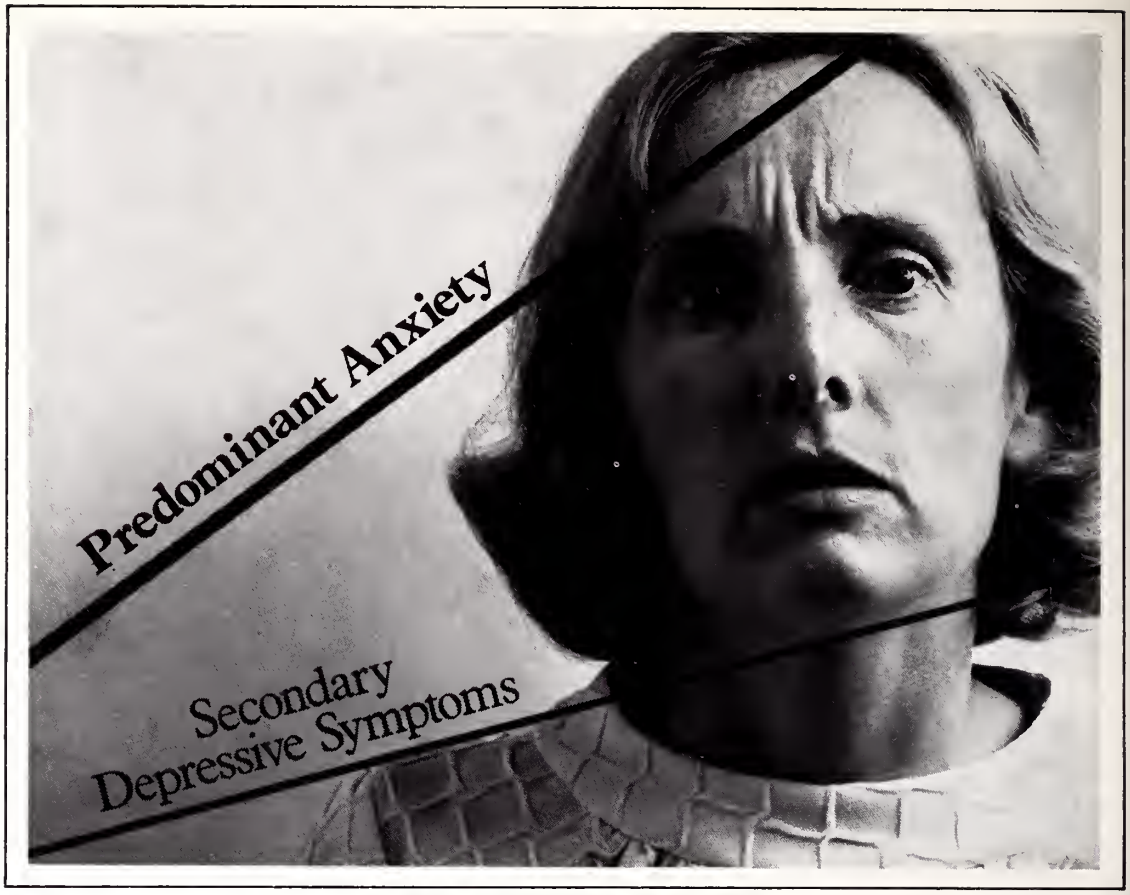

This psychoneurotic often responds

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

When you determine that the depressive symptoms are associated with or secondary to predominant anxiety in the psychoneurotic patient, consider Valium (diazepam) in addition to reassurance and counseling, for the psychotherapeutic support it provides. As anxiety is relieved, the depressive symptoms referable to it are also often relieved or reduced.

The beneficial effect of Valium is usually pronounced and rapid. Improvement generally becomes evident within a few days, although some patients may require a longer period. Moreover, Valium (diazepam) is generally well tolerated. Side effects most commonly reported are drowsiness, ataxia and fatigue. Caution your patients against engaging in hazardous occupations or driving.

Frequently, the patient's symptoms are greatly intensified at bedtime. In such situations, Valium offers an additional advantage: adding an *h.s.* dose to the *b.i.d.* or *t.i.d.* schedule can relieve the anxiety and thus may encourage a more restful night's sleep.

symptom complex to Valium® (diazepam)

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Division of Hoffmann-La Roche Inc.
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Valium® 2-mg, 5-mg, 10-mg tablets
(diazepam)

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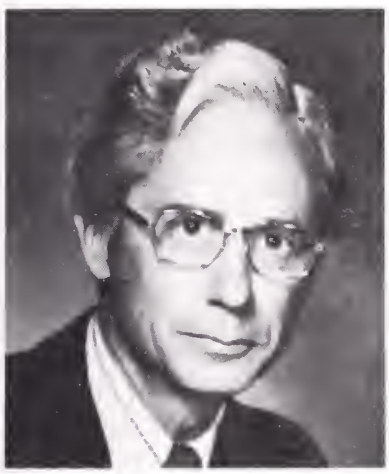
President's Page

Peer Review . . . 1973



Doctor Masters

The cry across the land is "peer review." Since Hippocrates, physicians have done peer review, so the present emphasis might seem strange if one did not consider history.

In less sophisticated times, and unfortunately even today in many areas, medicine's peer review has been spotty and, perhaps, superficial. It was enough to keep our profession "on the track" and to promote growth before the burst of scientific progress in the last quarter of a century. That level of peer review is not adequate today. Everyone knows why! Third party payers, medical care as a "right," rising costs, the rising public sophistication, etc., etc. It is not possible to condone longer the inept physician, to overlook excessive orders for laboratory or x-ray procedures, unfair charges, or any aspect of poor medical practice. "No way, baby!" PSRO, or the Bennett Amendment, has changed all that.

I, too, am very worried about the implications of this new law of the land. But it says to me that the people are demanding that we upgrade peer review to meet today's level of medical expertise; not with old fashioned ideas but with brand new computer technology that will bring the best quality medical care to all patients. And, don't forget that at the moment PSRO states that we are to do the peer review, no one else. We must not flub this directive, for if we do, there will be others who will set the standard and monitor our practice. (Somehow this fact alone negates the arguments of those who would have us resign from PSRO. Where does that leave us, except in a blind alley with no room for maneuver?)

What should we do? Let us objectively and without passion honestly evaluate today's medical practice and point out how it might be improved and how it might cost less. I am aware, for example, that radiologists themselves believe that 20 to 30 per cent of all x-ray examinations are unnecessary; I know conscientious radiologists who deplore the percentage of "negative" G-I series or skull examinations they report. Why shouldn't we tell the public that we know this is going on, that it is done more from their demands and the threat of malpractice than from good medical practice dicta?

Or how about examining the way "routine" orders go on ad infinitum at your hospital? How many reactive VDRLs has your laboratory reported on "every admission screening?" Or how productive, really , is the pre-operative chest x-ray (as compared to a good history and physical exam)? And there is the patient who is "tired" and comes into the hospital for a check-up? (Should he be there?)

Let's admit that these things do go on and appeal to our patients for their support in eliminating them, so as to concentrate our energies on improving the care they really need while at the same time substantially reducing costs.

The problem that we face involves many individuals and it would be an "easy way out" to seek repeal of PSRO, but it is imperative that the doctors of this country assume the leadership that is so vital today.

Let us not give up our "right" to be responsible for the total care of our patients.

Brooker L. Masters, MD

280857
MAY 1 1979

acute
gonorrhea
This patient
just received
an effective, private,
physician-controlled
treatment.
It took just one short visit...
Trobicin
Upjohn
*Urethritis, cervicitis, proctitis when due
to susceptible strains of N. gonorrhoeae
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Trobicin—The advantage of injectable therapy.
Once Trobicin is injected, treatment is usually complete; there can be no problems with patients sharing, skimping, skipping or forgetting medication.

Trobicin—The aspect of privacy.
There are no prescriptions to fill, no capsules to take. Neither family, friends nor co-workers need know or suspect the patient's problem.

Trobicin—Indication and dosage.
Spectinomycin is indicated only for use in acute urethritis and proctitis in the male and acute cervicitis and/or proctitis in the female when due to susceptible strains of *N. gonorrhoeae*. The usual dosage for Trobicin in adult males is 2 grams intramuscularly†; 4 grams intramuscularly in females.

Trobicin—Not effective for syphilis.
Trobicin is not effective for any stage of syphilis. Trobicin may mask or delay the symptoms of incubating syphilis. If concurrent syphilis is suspected, follow the patient serologically for at least 3 months. Patients with syphilis should receive adequate specific anti-syphilitic therapy with an appropriate antibiotic.
Trobicin is contraindicated in patients previously found hypersensitive to it.

Intramuscular

...and Trobicin® 2 gm and 4 gm vials
sterile spectinomycin hydrochloride

Sterile Trobicin
Sterile Trobicin (spectinomycin hydrochloride) —For Intramuscular Injection:
2 gm vials containing 5 ml when reconstituted with diluent.
4 gm vials containing 10 ml when reconstituted with diluent.
An aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria gonorrhoeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between spectinamycin and penicillin.

Indications: Acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

Contraindications: Cantraindicated in patients previausly found hypersensitive to spectinomycin.

Warnings: Not indicated for the treatment of syphilis. Antibiotics used to treat ganarrhea may mask or delay the symptoms of incubating syphilis. Patients should be carefully examined and monthly seralogical follow-up far at least 3 months should be instituted if the diagnosis of syphilis is suspected.
Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions shauld be observed with atapic individuals.
Clinical effectiveness shauld be monitored to detect evidence of development of resistance by *N. gonorrhoeae*.

Adverse reactions: The fallowing reactians were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dase subchronic tolerance studies in narmal human volunteers, the following were noted: a decrease in hemaglabin, hematocrit and creatinine clearance; elevation of alkaline phasphatase, BUN and SGPT. In single- and multiple-dose studies in normal volunteers, a reductian in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25° C and use within 24 hours after reconstitutian with diluent.

Male—Inject 5 ml intramuscularly far a 2 gram dose. Patients with ganarrheal proctitis and patients being re-treated after failure af previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is knawn ta be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.

Female—Inject 10 ml intramuscularly far a 4 gram dose.

How supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9%* w/v. Recanstitution yields 5 and 10 ml respectively with a concentration af 400 mg spectinomycin per ml (as the hydrachloride). Far intramuscular use only.
Susceptibility Powder—far testing *in vitro* susceptibility af *N. gonorrhoeae*.
Caution: Federal law prohibits dispensing without prescriptian.
For additional product information see your Upjohn representative or consult the package insert.

Upjohn

MED B-5-5 (MBR 1)
The Upjohn Company, Kolamazoo, Michigan 49001

† For patients with gonorrheal proctitis and for patients in geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams is preferred.

Maternal and Perinatal Health Conference Set for March 27 and 28 in Grand Rapids

Lloyd A. Kammeraad, MD, of Grand Rapids, has announced the preliminary program for the 1974 Michigan Conference on Maternal and Perinatal Health to be held March 27 and 28 in the Pantlind Hotel in Grand Rapids. More than 700 physicians, nurses and students attended the 1973 conference sponsored a year ago by the MSMS Committee on Maternal and Perinatal Health.

Doctor Kammeraad

The Wednesday morning session will offer a program arranged by the Nurses Association of the American College of Obstetricians and Gynecologists, Michigan Section, with the afternoon program to be devoted to the high risk obstetrical patient. There will be a slide presentation on "Identification and Evaluation of the High Risk Obstetrical Patient" and discussions on socio-economic, medical and nutritional factors in epidemiology of perinatal loss. Also scheduled for the afternoon are a slide presentation on "Antepartum Evaluation of the High Risk Obstetrical Patient" and discussions on "Ultra Sound for the Evaluation of Fetal Growth and Maturity" and "Intrauterine Fetal Growth Retardation."

Thursday's program will be devoted to team approaches to labor and delivery and to neonatal problems. After a slide presentation on "Detection of Fetal Distress in Labor," discussions will be presented on "The Nurse's Role in Fetal Monitoring," "The Effects of Analgesia and Anesthesia During Labor" and "Care of Emergencies in Labor." The final session will be devoted to discussions on "Specialized Problems of the Newborn," "Care of the High Risk Family" and "Is It Worth It?—A Critical Question."

Questions concerning the conference may be directed to Doctor Kammeraad or to Helen Schulte of the MSMS staff.

Michigan, California Schools Plan Admissions Experiment

The medical schools of Michigan and California have announced plans to implement a trial matching program for students applying for admission.

If successful, the program may eventually spread nation-wide, according to Ralph E. Lewis, executive director of the Council of Deans of the Michigan Medical Schools.

The program would be similar to that now used nationally to match interns and residents with training hospitals.

Currently, Lewis said, some 40,000 applicants file 400,000 applications for 14,000 openings in the nation's medical colleges. Last year there were more than 10,000 applicants who applied to the three Michigan medical schools for approximately 550 first-year places. Most of these applicants applied to all three schools. The result is months of work by admissions committees in reviewing applicants who have not only applied to other Michigan schools but to an average of seven medical schools in hopes of being picked by one.

The present application procedure would be replaced by a ranking system in which each medical school would list its freshman "ideal" class plus alternates and each applicant would rank schools in order of preference. An applicant who has been accepted would be matched with the school which he has ranked the highest on his list. The problem of multiple acceptances would be eliminated. The uncertainty as to which and how many students will enroll is eliminated on the part of the schools. And since applicants can hold only one place, the waiting list is reduced considerably. Results would be announced on a single date shortly after the matching process has been completed.

The trial program is under the auspices of the Association of American Medical Colleges and will be tested in parallel with the regular application process for the entering fall class of 1974. The colleges will decide if the system works by comparing the class they actually accept with the class they would have had if the matching system had been used.

A benefit of the program, Lewis believes, would be to put into focus the distorted picture of medical education opportunities in the United States. Due to the current multiple applications system, it appears there are dozens of qualified applicants for each medical school opening when, in reality, more than a third of all students who apply are accepted at some medical school in this country.

Participating in the trial program will be the three MD producing institutions in Michigan — Wayne State University School of Medicine, University of Michigan Medical School, Michigan State University College of Human Medicine — and eight medical colleges in California.

Must vasodilators and therapy for other diseases come into conflict?

not if the vasodilator is

VASODILAN®
(ISOXSUPRINE HCl)

the compatible vasodilator... no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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Around Michigan

Does Our Profession Still Adhere to the Old Standards of Conduct?

By Carl H. Moberg, MD
1973 President,
Kent County Medical Society

It has come to my attention recently that some of our society members are not carrying their share of the traditional responsibilities of medicine. These are precepts which have made our profession great.

A patient who had been under the care of one of our doctors for several years finally came upon hard times and had to resort to Medicaid. When she came in for a short exam she was told by her doctor: "You can no longer afford me and you will have to go elsewhere." Where may I ask is "elsewhere"? It is most certainly to the office of one of our members who considers the care of the poor a sacred trust.

We, as physicians, may be unhappy about Medicaid payments and if this is the case we have the option of caring for them free of charge as we did just a few years ago.

Certainly Medicaid patients should be cared for in each physician's office so that no single physician shall carry an excess burden. It is our responsibility to care for Medicaid patients equally, willingly and with the same compassion and expertise which we hopefully shower upon our regular patients.

There must be no second class citizens when it pertains to medical care, and if we do not accomplish this goal in the same manner as our older colleagues in the past, someone will "break our backs" and we will jolly well deserve it.

We have an inherent right to negotiate for decent and equitable payments from the Department of Social Services and this is being done for us by our liaison committee from the Michigan State Medical Society.

If we have problems, we must face them unitedly and not decide in our own self serving interests that we have no responsibilities to the sick who happen to be poor.

From the Bulletin of the Kent County Medical Society.

Richard C. Deming, MD, (right) of Jackson, recently was presented with the Outstanding Achievement Award for the State of Michigan from the National Easter Seal Society for Crippled Children and Adults. Marvin E. Raguse, (left) past president of the Jackson Rotary Club, made the presentation, which was held at a meeting of the Jackson Rotary Club because Doctor Deming had been unable to attend the society's earlier awards ceremony. Doctor Deming was responsible for the founding of the Jackson County Crippled Children's Society and has served on its board for 20 years. He is a past president of the Jackson County Medical Society. (Jackson Citizen Patriot Photo by Bob Keyes.)

Integument!

Our skin—the human integument—covers us, defines us, protects us. But skin is subject to cuts, burns, abrasions. And infections. Neosporin Ointment fights infection by providing broad antibacterial action against susceptible skin invaders. It contains antibiotics that are rarely used systemically, reducing the risk of sensitization.

INDICATIONS: *Therapeutically,* used as an adjunct to appropriate systemic therapy for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

PRECAUTION: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Complete literature available on request from Professional Services Dept. PML.

NEOSPORIN® Ointment

(POLYMYXIN B-BACITRACIN-NEOMYCIN)

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg. (equivalent to 3.5 mg. neomycin base); special white petrolatum q.s. In tubes of 1 oz. and ½ oz. and 1/32 oz. (approx.) foil packets.

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More than sleep.

your choice of sleep medication is wisely based on more than sleep-inducing potential

sleep with relative safety

Chronic tolerance studies have confirmed the relative safety of Dalma (flurazepam HCl); no depression of cardiac or respiratory funct was noted in patients administered recommended or higher do for as long as 90 consecutive nights.

In most instances when adverse reactions were reported, they were mild, infrequent and seldom quired discontinuance of therapy. Morning "hang-over" with Dalmane has been relatively infrequent. Di ness, drowsiness, lightheadedness and the like have been the side effects noted most frequently, particularly in the elderly and debilitated. (An initial dose of Dalmane 15 mg should be prescribed for these patients.)

sleep for 7 to 8 hour without need to repeat dosage

No sleep m cation has been as rigorously evaluated in the sleep research laboratory as Dalmane. Insomnia patie given one 30-mg capsule of Dalmane at bedtime, on average: fell asleep within 17 minutes, had fewer nig time awakenings, spent less time awake after sleep onset, and slept for 7 to 8 hours with no need to rep dosage during the night.

eep with
onsistency

Dalmane has been shown to be consistently effective even during consecutive nights of administration, with no need to increase dosage.

Dalmane (flurazepam HCl) is a distinctive sleep medication—a zodiazepine specifically indicated for insomnia. It is not a barrate or methaqualone, nor is it related chemically to any other lable hypnotic.

When your evaluation of insomnia indicates the need for a sleep dication, consider Dalmane—a single entity nonnarcotic, nonbiturate agent proved effective and relatively safe for relief of omnia.

DALMANE®
(flurazepam HCl)

When restful sleep is indicated

One 30-mg capsule *h.s.*—usual adult dosage
(15 mg may suffice in some patients).
One 15-mg capsule *h.s.*—initial dosage for elderly or debilitated patients.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening, in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

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The American Academy of Dermatology

The Board of Directors of the American Academy of Family Physicians

The Executive Board of the American Academy of Neurology

The Committee on Drugs of the American Academy of Pediatrics

The American College of Allergists

The Executive Committee of the American College of Obstetricians and Gynecologists

The Board of Regents of the American College of Physicians

The Board of Trustees of the American Dental Association

The Board of Trustees of the American Medical Association

The American Psychiatric Association

The Executive Committee of the National Association of Retail Druggists

The Board of Directors of the Pharmaceutical Manufacturers Association

The National Wholesale Druggists' Association

Joint Statement on Antisubstitution Laws and Regulations

The purpose of this statement is to affirm the support of the participating organizations for the laws, regulations and professional traditions which prohibit the unauthorized substitution of drug products.

Traditionally, physicians, dentists and pharmacists have worked cooperatively to serve the best interests of patients. Productive cooperation has been achieved through mutual respect as well as a common concern for the ideals of public service. This mutual respect has been reflected, in part, by joint support over the years for the adoption and enforcement of laws and regulations specifically prohibiting unauthorized substitution and encouraging joint discussion and selection of the source of supply of drug products. The basic principles of medical, dental and pharmacy practice are thus utilized and preserved in the interest of patient welfare.

The antisubstitution laws have not obstructed enhancement of the professional status of pharmacy any more than they have in and of themselves guaranteed absolute protection from unsafe drugs, or freed physicians, dentists and pharmacists from their responsibilities to patients. As a practical matter, however, such laws and regulations encourage interprofessional communications regarding drug product selection and assure each profession the opportunity to exercise fully its expertise in drug usage, to the advantage of patients.

Physicians and dentists should be urged to increase the frequency and regularity of their contacts with pharmacists in selection of quality drug products, recognizing that economies to patients can be improved through such communication, taking into account the patients' needs. The pharmacist's knowledge of the chemical characteristics of drugs, their mode of action, toxic properties and other characteristics that assist in making drug selection decisions should be utilized to the fullest extent practicable by physicians and dentists in serving their patients.

Since drug product selection entails knowledge derived from clinical experience, the physician's and dentist's roles in product selection remain primary and do not permit delegation of decisions requiring medical and dental judgments. A broader role in therapy will evolve for pharmacists as improved understanding and cooperation among the professions continue to grow.

There has been no evidence that there are convincing reasons to modify or repeal existing laws and regulations prohibiting the unauthorized substitution of another drug product for the one specified by a prescriber. It is our belief that such laws and regulations merit the joint support of the medical, dental and pharmaceutical professions and the pharmaceutical industry.

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Acupuncture for Pain Relief, a Double-blind, Self-controlled Study

By Pang L. Man, MD
Calvin H. Chen, MD, MSc. (Med.)
Northville

Thirty-six patients suffering from chronic intractable pains of varying etiology were given the simulated and real acupuncture in this double-blind self-controlled study. The overall improvement rate with real acupuncture was 72.1 percent. The most remarkable results were obtained in neuralgia patients (92.9 percent). The psychological effect was insignificant (11.1 percent) and ill effects nil.

Acupuncture did not seem to benefit pains caused by any pressure on the nerves such as due to scarring or constriction, nor did it work if the nerves were severed. In case of hysterical pains, the results were unpredictable. These are understandable because according to our two-gate control theory the analgesic effect of acupuncture depends on functioning peripheral nerves and not psychology. If we were to eliminate these cases, eight in number, the real overall success rate would be 82.1 percent.

From our experience we feel that the number and frequency of treatment should be individualized according to the patient's response. Likewise, a maintenance treatment regime for a varying period of time is necessary in most cases. Further research is warranted to determine the precise indications and treatment regimes.

Ever since acupuncture was widely publicized in this country in 1972 the main controversy has been centered around the question of whether its analgesic effect and other claims are genuine or psychological. The critics feel that the Chinese cultural and political systems are so different from those of the United States that even if their claims were true, acupuncture would not produce the same beneficial effects in this country. The justification for skepticism is enhanced by the relative disinclination of the Chinese in the People's Republic of China to do well-controlled clinical studies and their dependency on empiricism and decades, centuries, if not millennia of experience.

In spite of the doubts and criticisms, serious basic and applied scientific investigations are underway in many medical research centers. Both the American Medical Association and the National Institutes of Health are definitely in favor of these studies; the latter recently held a national Acupuncture Research Conference to exchange ideas among researchers in the field and would even fund certain projects. The circumstances are such now that we can no longer ignore the existence of acupuncture. The public, especially the millions of sufferers from intractable pain, demands that scientific studies be conducted to either verify or discount the innumerable eyewitnessed reports by medical experts and intelligent lay people. Also, if acupuncture is proven to be useful as a modality of medical therapy and surgical analgesia, one would like to know exactly where its niches are in our medical armamentarium.

(Continued)

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In order to help answer one of the many questions, namely, the analgesic effect, the authors had previously undertaken several other studies.[1-3] The following is the report of double-blind self-controlled research on 36 patients suffering from chronic severe pains of various etiology. It was intended to be a study of pain control as a whole and not for any single diagnostic entity. Most patients in this group had been thoroughly worked up and treated at the best medical centers or clinics in the country and/or the world but had failed to obtain satisfactory relief. They came to us as a last resort and often with an attitude of "nothing to lose." They may be properly called "failures" of modern medicine.

Research Methodology

Selection of Patients: All patients were volunteers and were asked to have their responsible physicians send us a detailed medical summary for preliminary screening. The following criteria were used:

1. Chronic severe pain with no trend of remission, poorly or not relieved by the best conventional Western scientific treatment modalities.
2. Well-established diagnosis with no organic basis.
3. Willingness and ability to tolerate the required discontinuation of pain medications during the research period.
4. No history of emotional or mental illness.
5. No inclination to suggestibility.
6. Normal intelligence and ability to cooperate and report accurately any changes of the character and degree of the pain.

If a case appeared to be suitable after a careful review by the research team, he was asked to come for a personal interview and a brief physical and mental examination. If it was confirmed that he fit the above criteria, he was asked to sign an informed consent form and to discontinue whatever pain medication he was taking prior to his admission into the research project. A few exceptions were made in order to see if pain caused by hysteria would be benefited.

Of the 36 patients so selected, 10 were men and 26, women. Their ages ranged from 23 to 79 years (average 53.1 years). Their duration of pain varied from one to 32 years (average 6 years), and their degree of pain from mild in four, moderate in 16 to severe in 16. The diagnoses were neuralgias, low back pain, arthritis, hysterical headaches, tennis elbow, post-cancer operation pain (rectum, breast), paraplegia and carpal tunnel syndrome *(see Table 1).*

Procedure: The double-blind control method was employed. Neither the patient nor the physician-evaluator knew whether or when the simulated or real acupuncture was given. No suggestion of the merits of acupuncture was made. Patients were scheduled as much apart as possible to minimize the opportunity of meeting and talking among themselves to "compare notes." Furthermore, he was told that we were not sure if acupuncture would help him, hence the research to find out the truth, and to report the results as factually as possible.

The real acupuncture consisted of inserting two needles in the most painful areas along the pathway of the nerve supply, making sure that the patient felt either tingling or numbness or both which signified that the needles had come into contact with a peripheral nerve or one of its branches.[4] The traditional acupuncture points were deliberately avoided because we believe that the mechanism of pain relief by acupuncture cannot be explained by the meridian theory but is

Table 1

Diagnosis

NEURALGIAS										
Trigeminal	Postherpatic	Traumatic intercostal	Occipital	Low back pain	Arthritis	Hysterical headaches	Tennis elbow	Post cancer operation pain	Paraplegia with pain	Carpal tunnel syndrome
10	1	2	1	7	6	3	2	2	1	1

Table 2

Results of Simulated and Real Acupuncture for Pain Relief (36 patients)

	Completely Relieved	Markedly Improved	Moderately Improved	Mildly Improved	Unchanged	Worse
Simulated acupuncture period	1	3	0	0	32	0
Real acupuncture period						
After 5 treatments	0	12	7	5	8	0
After 10 treatments	1	17	1	4	9	0

primarily based on our two-gate control theory.[1-3] The needles were then connected to a Chinese acupuncture machine powered by a 9-volt battery. The sine wave of 50 Hertz was used. The intensity of the current was gradually increased stepwise every two to three minutes according to the patient's ability to tolerate it, for 30 minutes. No patient felt uncomfortable during this procedure. All the patients were taught to adjust the current output control knob themselves. A simulated acupuncture was conducted in the same manner except that the two needles were deliberately inserted far away from the painful area without eliciting tingling or numbness and the current was not turned on. The patients were informed that different acupuncture techniques would be used. Since they did not know the technical details of acupuncture, they had no idea as to when they received the simulated or the real treatment.

All subjects served as their own control by starting on the simulated treatment for as long as they could tolerate without medication which varied from a few days to two weeks. Then they were given the real acupuncture treatment consisting of 30 minutes of treatment, five days a week for two weeks. Of course, if the patient was completely relieved of his pain in two weeks, no real acupuncture treatment would follow. All patients were rated by the "blind" physician-evaluator before the research began and at least weekly as long as they were on the simulated or real acupuncture. Thereafter they were followed up by a questionnaire sent to them monthly for three months. The rating scales were as follows: completely relieved, markedly improved, moderately improved, mildly improved, unchanged and worse.

Case Reports: The following representative cases are reported in some detail to give the readers a better insight into the actual clinical experience:

1. A female patient, 53, the manager of a group of physicians' three offices for 17 years, had suffered from left trigeminal neuralgia of all three branches for the last 11 years. She had had extensive medical examinations and treatments without improvement. The treatments included three nerve blocks, a maxillary branch denervation, carbamazepine (Tegretol) six 200 mg. tablets daily, plus meperidine (Demerol) 100 mg., as needed, and yet she was unable to sleep well at night and regularly woke up at 3 a.m. because of pain. She could not use any makeup, brush her teeth, wash her face or eat any solid food. Even the breath of another person would trigger an excruciatingly painful attack, not to mention the blowing of the wind on her face, light touch or sneezing. Suicidal thoughts frequently preoccupied her mind.

All pain medications were discontinued during the simulated acupuncture period. For three days she almost "climbed up the wall" with tears streaming down her face. We were then quite certain that there was no placebo effect and that the pain was genuine, so we switched her to the real acupuncture. Immediately after the first treatment the pain diminished considerably. At the end of the fifth treatment, she reported to the independent rater that she was 80 percent improved, and at the end of the tenth treatment, 90 percent improved. As to the remaining 10 percent of pain, the patient said, "I could live with it easily." Her family physician was so astonished that he made a special trip to our clinic to observe the procedures to ascertain that no tricks or hypnosis was used. During the three months of follow-up period, her pain gradually increased and fluctuated between 50-70 percent of her pretreatment level.

2. A 38-year-old female school principal from Minnesota suffered from an unusual intercostal neuralgia as a result of a flail chest caused by an

(Continued)

automobile accident five years ago. Since then she had been treated by different well-known physicians and at various best clinics in the country with no improvement. Finally she was told that she had to live with it. After having heard such a verdict she attempted suicide by taking a large amount of "pills." Fortunately, she was hospitalized in time and recovered from the incident.

All pain medications were discontinued during the simulated acupuncture period causing her pain to increase considerably. She became despondent and depressed thinking that acupuncture would not help her. After a week she was switched to the real acupuncture. From then on she began to notice improvement. At the end of the fourth treatment she was definitely improved and at the end of the seventh treatment she was completely free from any pain. After the tenth treatment she happily went home for Thanksgiving. During the follow-up period, 10 percent of her pain had returned but this was quite easily tolerated.

3. A 43-year-old professor from Ohio suffered from paraplegia after an arteriogram two years ago. In addition to paraplegia, he complained of severe pain in his legs 24 hours a day. No treatments such as bilaterally sympathetic nerve block or analgesics were of any help. The patient had marked atrophy of the lower extremities and was incontinent. After simulated treatment of three days the real treatment was given for the usual two weeks. At the end of ten treatments and during the follow-up period the patient showed no improvement at all.

Discussion

From our study, the overall success in this group of heterogeneous patients was 72.1 percent. If a patient's pain was caused by hysteria (one received only the simulated acupuncture and three the real acupuncture), the results were inconsistent. This is to be expected because we believe that the mechanism of action of acupuncture analgesia is a neurological one.[1-8] We also found that acupuncture is ineffective in conditions where there is any organic interference with the conduction of nervous impulses such as the nerves having been cut, pressed by the scar tissue, or compressed by the fibrous sheath. However, even some of these patients had good immediate results lasting from a few hours to more than a day.

Typically, the majority of patients remained unimproved during the simulated acupuncture period and immediately showed highly significant progressive improvement once they were switched to the real acupuncture. In these cases one must assume that the psychological factor was irrelevant.

Among our 36 patients, the largest group consisted of neuralgias of one kind or another (14 cases), the second largest group was low back pain (seven cases) and the third largest group was various types of arthritis (six cases). From our experience, neuralgias seemed to respond most remarkably to acupuncture treatment with a 92.9 percent success. Other chronic pains also responded well except those conditions stated in the first paragraph.

Results

None of the 36 patients' chronic pain became worse during the entire research period. No one suffered any ill effects. There were four patients (11.1 percent) who received only the simulated acupuncture for two weeks and whose pain was markedly relieved. Their diagnoses were: trigeminal neuralgias, 1, rheumatoid arthritis, 2, and hysterical low back pain, 1. Of the remaining 32 patients, all were likewise started with the simulated acupuncture but all showed no improvement; therefore, they were all switched to the real acupuncture. The results after five and ten real acupuncture treatments are shown in Table 2. After ten real acupuncture treatments, 1 patient (3.1 percent) was completely relieved of pain, 17 (53.1 percent) markedly improved, 1 (3.1 percent) moderately improved, 4 (12.5 percent) mildly improved and 9 (28.2 percent) unchanged.

Of the nine patients who did not improve with the real acupuncture, two suffered from headaches due to hysteria and one each from trigeminal neuralgia, hysterical low back pain, tennis elbow, postoperative rectal cancer, radical mastectomy, paraplegia and carpal tunnel syndrome.

During the three months of follow-up period, of the four patients whose pain was very markedly relieved by the simulated acupuncture, one (hysterical low back pain) had the pain returned in full almost immediately, one (neuralgia) returned gradually to 40 percent and two (arthritis) to 20 percent and 50 percent of the pre-acupuncture level, respectively. Among the 32 patients who did receive the real acupuncture, one remained pain free, two had a 25 percent recurrence of pain, four had a 50 percent recurrence, 16 had an 80 percent recurrence and the nine who did not show improvement during the treatment remained unchanged.

We cannot explain why three of the four cases became very markedly improved with the simulated treatment except for one of them whose low back pain was due to hysteria. The improvement of the other three perhaps may or may not be attributable to psychological effects. However, even if all these four cases were attributed to psychological effects the percentage (11.1 percent) is far below the usual percentage that is generally encountered in any doctor-patient relationship.

In view of the foregoing discussion we may say that the 76.5 percent overall success is more apparent than real. If we were to eliminate hysteria

(Continued on Page 24)

In recent years there has been an increased awareness of mild hypercalcemia in hyperthyroidism. Symptomatic hypercalcemia, however, is unusual and a literature review disclosed only 22 patients with symptomatic thyrotoxic hypercalcemia. This report adds an additional five cases and suggests that this entity is more common than was previously appreciated. Symptoms of anorexia, nausea, vomiting and marked weakness suggest hypercalcemia. These are features which also may be seen with severe hyperthyroidism. Since primary hyperparathyroidism can occur with hyperthyroidism, determining the cause of the hypercalcemia may be difficult. Factors favoring thyrotoxic hypercalcemia include its correction by an antithyroid program or glucocoricoids. Concurrent hyperparathyroidism is probable when these measures do not affect the hypercalcemia or when radiographic subperiosteal bone erosions are present. It is emphasized that symptomatic hypercalcemia must always be considered as a factor contributing to the debilitating manifestations encountered in severe thyrotoxicosis.

Symptomatic Thyrotoxic Hypercalcemia

By Donald A. Meier, MD, Southfield
A. Robert Arnstein, MD, Detroit
Joel I. Hamburger, MD, Southfield

Introduction

Hypercalcemia as a manifestation of hyperthyroidism, recently reported with increasing frequency, was considered uncommon until 1966 when Baxter and Bondy found elevated serum calcium levels in 17 of 77 hyperthyroid patients.[1] They concluded that mild but significant hypercalcemia was commonly present in thyrotoxicosis and was usually asymptomatic. A review of the literature has disclosed only 22 patients with symptomatic thyrotoxic hypercalcemia in contrast to asymptomatic hypercalcemia that not uncommonly accompanies hyperthyroidism. This report adds an additional five cases and suggests that symptomatic hypercalcemia should be considered as an unexpected factor contributing to the morbidity of severe thyrotoxicosis.

Doctor Arnstein is associate professor of medicine at the Wayne State University School of Medicine, where Doctor Meier is adjunct assistant professor of medicine. Doctors Meier and Hamburger are affiliated with the Northland Thyroid Laboratory, Southfield.

Case Reports

Case #1

A 39-year-old man was first referred to the Northland Thyroid laboratory in 1964 when he was found to have a hypofunctional thyroid nodule which was excised and found to be benign.

In November, 1969, he complained of marked weakness, a 40 pound weight loss in the preceding four months, anorexia, heat intolerance and palpitation. He had a diffuse goiter, about three times normal size, fine moist skin, a regular heart rate of 110/min and a fine tremor of the outstretched fingers. The serum thyroxine by competitive protein binding (T^4) was 9.2ug% (normal: 3.0-6.5ug%), the T_3 resin uptake (T_3) was 52% (normal: 25-35%) and the 24-hour radioactive iodine uptake

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(RAI) was 72%. A serum calcium was not done. A diagnosis of thyrotoxicosis was made and he was treated with 7 mCi of ^{131}I, followed in 72-hours by Lugol's solution, 3 drops daily, to bring about a more rapid resolution of the hyperthyroidism.

One month later he had lost another 25 pounds and complained of marked weakness, anorexia, nausea, vomiting, polydipsia and polyuria. He was dehydrated. Laboratory studies revealed 3+ proteinuria, T_4 9.8ug%, T_3 50%; serum calcium 16.8mg%, serum inorganic phosphorus, 2.8mg%, BUN 36mg% and serum creatinine, 2.2mg%. He was promptly hospitalized and treated with vigorous intravenous fluids, propylthiouracil (PTU) 300mg every six hours; Lugol's solution, 5 drops daily, and cortisone, 200mg daily by mouth. With hydration the serum calcium fell to 14.7mg% in 24 hours, to 12.8mg% in 96 hours and to 11.6mg% in 10 days. Serum inorganic phosphorus levels on eight determinations ranged between 2.1 and 3.2mg% with a mean of 2.8mg% (normal 3.0-4.0mg%). Urinary calcium excretion was 820mg per 24 hours, serum alkaline phosphatase was 10.7 KA units (normal 10-15) and serum albumin was 3.3gm%. Radiographs of the chest, skull, clavicles, hands and intravenous pyelogram were normal. Nausea, vomiting, polydipsia and polyuria disappeared within 24 hours. In three weeks he gained 20 pounds, and his serum calcium was 10.4mg%; serum phosphorus, 4.3mg%, T_4 6.2ug%, BUN 15 mg%, and the urinalysis was normal. The cortisone and Lugol's solution were discontinued and the PTU was decreased to 100mg twice a day and then discontinued two weeks later when his T_4 was 4.7ug% and serum calcium 10.0mg%. Five months after the ^{131}I therapy the T_4 was 5.4ug%, but 12 months post-therapy he appeared hypothyroid with a T_4 of 1.2ug% and a serum calcium of 10.0mg%. Since then he has been maintained on 0.2mg of levothyroxine daily and has remained well.

Comment: The patient's weakness and weight loss were initially attributed to severe hyperthyroidism. It was not until one month later, with the development of nausea, vomiting, polyuria, polydipsia and dehydration that hypercalcemia was suspected. It may have been present at the onset, but, if so, was asymptomatic. Hypophosphatemia raised the question of coexistent primary hyperparathyroidism, but the rapid clinical and laboratory response to glucocorticoids and antithyroid therapy ruled out this diagnosis. The proteinuria and renal insufficiency probably represented reversible hypercalcemic nephropathy.[2]

Case #2

R.C., a 25-year-old man, was admitted to Wayne County General hospital on May 30, 1964, with a midshaft fracture of the left femur. He gave a two-year history of heat intolerance, palpitation and sweating. There was slight stare, lid lag, proptosis, fine tremor of the outstretched fingers, warm, moist and smooth skin and a diffuse goiter about five times normal size. The heart rate was regular at 110 beats per minute. Pertinent laboratory data included an RAI of 87%; T_3 56%; alkaline phosphatase 6.6 Bodansky units; serum albumin 3.3gm%, serum creatinine 0.6mg% and a BUN 15mg%.

The thyrotoxicosis was treated with methimazole, 30mg every eight hours and the fracture with traction. Within a week, he became agitated and restless and developed a sinus tachycardia with a rate of 152 per minute, a gallup rhythm and a temperature of 100.8 F. Thyroid storm was suspected and he was given intravenous fluids, sodium iodide, cortisol and intramuscular reserpine with improvement. After 17 days in traction, and 7 days after cortisol was stopped, anorexia and severe vomiting began. At this time a serum calcium was 16.2mg% and a serum phosphorus, 3.3mg%. Radiographs of the hands were normal. Films of the femur showed no signs of healing. Five days later, after hydration and 3 days of glucocorticoids, his serum calcium was 12.9mg%. The anorexia had improved and vomiting had stopped. The tubular reabsorption of phosphorus (TRP) was 95%; and the 24-hour urinary calcium excretion was 602mg. The serum calcium fell to 9.4mg% with continued antithyroid therapy.

Eleven weeks after admission methimazole was stopped. A PBI was 4.4ug% (normal 4.8ug%), T_3 41% and 24-hour RAI 54%. He was then treated with 10 mCi of ^{131}I, followed by methimazole maintenance. During the four months after ^{131}I therapy, he remained euthyroid (PBI 5.9ug%) and his serum calcium was between 9.7 and 11.0mg%.

One year after radioiodine therapy, he refractured his left femur. He had discontinued methimazole and was again thyrotoxic, with anorexia, nausea and dehydration. His PBI was greater than 15ug%; T_3 54%; serum calcium 14.0mg%; TRP 60%. Radiographs confirmed a new fracture at the old fracture site. Methimazole was again given, 30mg every eight hours. Anorexia and hypercalcemia (nine determinations between 12.1 and 14.3mg%) continued for the next month with a weight loss of 36 pounds. During the second month of methimazole administration, seven serum calciums averaged 11.9mg%, but by the end of three months he was clinically euthyroid. However, his serum calcium still ranged between 10.3 and 11.3mg%. Because of this persistent hypercalcemia and the earlier low TRP, a neck exploration with subtotal thyroidectomy and partial parathyroidectomy was done. Three histologically normal parathyroid glands were removed. After

surgery, the patient developed hypoparathyroidism and hypothyroidism.

Comment: Immobilization may have been a significant factor in the exacerbation of the hypercalcemia, leading to the clinical manifestations which appeared about 2½ weeks after the first admission. The response of hypercalcemia to the short course of glucocorticoids was equivocal. The refracture and recurrence of hyperthyroidism and symptomatic hypercalcemia might have been prevented by more effective treatment of his thyrotoxicosis on the first admission. Primary hyperparathyroidism was considered strongly enough to proceed with subtotal thyroidectomy and exploration of the parathyroid glands.

Case #3

R.S., a 55-year-old woman, came to the Henry Ford Hospital in October, 1968, complaining of fatigue for one year. For two months, she had increasing weakness, anorexia, nausea, vomiting, lower abdominal cramps, a 15 pound weight loss, polydipsia, polyuria and emotional lability. Her blood pressure was 150/70, pulse 80 and regular. The thyroid gland was slightly enlarged and lobular. A serum calcium was 16.1mg%. After hydration, serum calciums ranged from 11.5-12.6mg%. In the course of an evaluation for hypercalcemia, the PBI was found to be 14ug%; T_4 15.6ug% (normal 4.5-10.0ug%), T_3 1.15 (normal 0.8-1.3). Estrogen administration undoubtedly altered these values; however, the 24-hour RAI was 58%. The BUN was 14mg%, serum creatinine 0.9mg%, serum inorganic phosphorus 2.8 to 4.5mg%, serum alkaline phosphatase 4.4 to 4.7 Bodansky units, serum albumin 3.4gm%, 24-hour urinary calcium 29lmg. Radiographic survey of the bones and an intravenous pyelogram were normal. In retrospect she had mild stare, but symptoms of hypercalcemia dominated the clinical picture.

One week after admission, her hyperthyroidism was treated with 8.0mCi of ^{131}I followed by iodine administration, and one month later her serum calcium was 10.4mg%. The hyperthyroidism recurred when the Lugol's solution was withdrawn and eight months after her first treatment she was retreated successfully with 3.3mCi of ^{131}I. At the time of recurrence, her serum calcium was 10.6mg%. One year later when she was euthyroid, it was 10.0mg%.

Comment: This patient presented with a typical hypercalcemic syndrome that masked the signs and symptoms of thyrotoxicosis which, even in retrospect, were minimal.

Case #4

A 56-year-old female was admitted to Hutzel Hospital with a diagnosis of hyperthyroidism in February, 1971. She had a three month history of anorexia and nausea, a 20 pound weight loss and marked weakness. There was stare and lid lag. The thyroid gland was diffusely enlarged, about twice normal size, and there was evidence of mild heart failure and proximal muscle weakness. Her PBI was 11.9ug%, T_4 8.7ug% (normal 2.7-7.4ug%), T_3 37%, 24-hour RAI 70%, serum calcium 12.1mg%, serum inorganic phosphorus 5.2mg%, BUN 28mg%, serum alkaline phosphatase 102 I.U. (normal 30-85), serum albumin 3.7gm%, 24-hour urinary calcium excretion 49mg. A radiographic survey of the skeleton was normal.

Subsequent serum calciums ranged between 12.5 and 14.1mg%, and serum phosphorus 4.3-5.2mg%. One week after admission she was treated with 8mCi of ^{131}I and propranolol. Because of increasing dehydration and symptomatic hypercalcemia (including marked anorexia, nausea, lethargy and weakness) she was also treated with intravenous fluids and glucocorticoids. In five days the serum calcium was 11.3mg% and did not rise again after glucocorticoids were stopped shortly thereafter. Three months later she was euthyroid and her serum calcium was 10.1mg%.

Comment: This patient's symptoms were not as severe as those of the other three, but the manifestations of thyrotoxicosis were clearly aggravated by hypercalcemia.

Case #5

A 21-year-old female was admitted to Detroit General Hospital on Dec. 14, 1971, with a 10 month history of nervousness, sweating, heat intolerance, and a 15 pound weight loss. In addition there was a one month history of anorexia, polydipsia, polyuria and abdominal pain. The blood pressure was 130/60, pulse 120 and regular. The thyroid gland was diffusely enlarged about 3 times normal size. The T_4 was 27.5ug% (normal 5-13), T_3 50% (normal 35-45%), RAI was 35% at three hours and 44% at 24 hours. The BUN was 11mg%, creatinine clearance 63ml/minute, serum protein 6.6gm% with 3.6gm% albumin, serum alkaline phosphatase determinations were 85, 95 and 105 I.U. (normal 30-85). A roentenographic bone survey was normal as were x-rays of the hands. On Dec. 15, 1971, the patient was started on propranolol 30mg every six hours. During the next week four serum calcium determinations ranged from 11.1 to 13.2mg% with serum phosphorus values between 4.5 and 5.7mg%. Fifteen days after admission the patient was noted to be lethargic and somnolent and a serum calcium was 15.0mg%. She was started on IV fluids and furosemide. Subsequent daily serum calciums were 13.1, 13.3, 13.3, and 12.9mg% with phosphorus values from 4.0 to 5.3mg%. On Jan. 3, 1972, methimazole was started along with the propranolol, plus subse-

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quent Lugol's solution in preparation for a subtotal thyroidectomy, which was done on Jan. 21, 1972. Serum calciums on Jan. 28 and Feb. 4, 1972, were 9.6 and 10.2mg% and three weeks after surgery the T_4 was 4.2ug% with a T_3 of 1.0 (normal 0.87-1.13).

Comment: This patient also had hypercalcemic symptoms before admission. The rise in serum calcium two weeks after admission is somewhat surprising, but being inactive while on the ward was probably a factor. She was on nothing but propranolol during this interval.

Discussion

In 1949, Stanley and Fazekas[3] reported a patient with thyrotoxicosis and asymptomatic hypercalcemia. In 1966, Baxter and Bondy[1] found mild asymptomatic hypercalcemia in 20 percent of 77 hyperthyroid patients. They and Lim et al[4] found that, as a group, hyperthyroid patients have higher mean serum calcium levels than euthyroid controls even though none of Lim's patients' values were outside the normal range. Hyperthyroid patients with increased plasma ionized calcium levels may not have an elevation in total serum calcium concentration if there is concomitant hypoalbuminemia, a relatively frequent finding in hyperthyroidism.[5]

Symptomatic, in contrast to asymptomatic, hypercalcemia is uncommon in thyrotoxicosis.[2,6] Parfitt and Dent in 1970 reviewed 18 cases, including two of their own.[7] Since then, four additional patients have been reported.[8,9] All patients had gastrointestinal manifestations, particularly, anorexia, nausea and vomiting. Nikkila and Pitkanen described five hyperthyroid patients with vomiting as the dominant manifestation of thyrotoxicosis. The serum calcium level was elevated (11.6 and 12.1mg%) in one of two patients in whom it was measured.[10] Nausea and vomiting were also noted by Lahey in severe hyperthyroidism and impending thyroid storm[11], but the incidence of hypercalcemia in these patients is not known. Because nausea and vomiting do not usually occur in uncomplicated hyperthyroidism the presence of these symptoms should alert one to the probability that the patient is hypercalcemic. At times, these and other symptoms of hypercalcemia, such as polyuria and polydipsia, have overshadowed the signs and symptoms of hyperthyroidism,[8,12] as in our third patient.

Of the 22 cases of symptomatic hypercalcemia, 13 of 19 tested had laboratory evidence of renal impairment. Although the case reports do not provide adequate follow-up data regarding the renal status in all instances, in most cases renal function apparently returned to normal following correction of the hypercalcemia, but in at least two cases some permanent renal damage occurred.[7]

Data are less complete regarding the skeletal system. In three patients there were radiographic reports of varying degrees of osteoporosis.[7,13,14] Six patients had a high serum alkaline phosphatase level. Because this may reflect transient hepatic injury, common in thyrotoxicosis,[15] its significance in relation to bone involvement could not be estimated without alkaline phosphatase isoenzyme determinations. In the remaining 13 patients studies referable to bone were either normal or not done.

Radiographic evidence of bone demineralization is occasionally seen in hyperthyroidism but it is not usually symptomatic, except in older women, in whom it probably aggravates an underlying post-menopausal osteoporosis.[6] However, recent studies utilizing quantitative measurements of bone density[16] and high resolution radiography[17] showed, by the former, a consistent loss of bone density, and by the latter a regularly occurring loss of bone cortex in patients with thyrotoxicosis. As with post-menopausal osteoporosis, that associated with hyperthyroidism in older women, is probably not reversible.[16] Our second patient did not have radiographic evidence of osteoporosis, and the role of the hyperthyroidism in the original fracture is not clear. Refracture at the same site 15 months later suggests inadequate healing, and radiographs showed poor callus formation after the first fracture, for which the hyperthyroidism may have been a contributing factor.

The effect of thyroid hormone on bone metabolism has been well documented, but its mechanism of action on bone is not fully understood. An intravenous calcium load is disposed of more rapidly, with greater calcium retention in hyperthyroid patients.[4] Balance studies have shown negative calcium balance, due largely to increased urinary calcium excretion with variable effects on the intestinal absorption of calcium.[18] Radiocalcium kinetics show increased turnover and increased bone accretion and resorption rates.[6] Microradiography shows increased bone resorption and formation surfaces, the former greater than the latter.[19] Urinary hydroxyproline is also increased.[6] These changes are the result of a high rate of bone resorption which exceeds bone formation. Thyroid hormone probably stimulates bone resorption primarily, which, in turn, calls forth increased osteoblastic activity.[20]

Why hypercalcemia develops at all in hyperthyroidism is unknown. Its occurrence does not necessarily correlate with the clinical severity of thyrotoxicosis.[1] Excessive bone resorption may simply exceed the capacity of the kidneys to excrete the extra calcium load. Parfitt and Dent[7] have discussed this and other possible mechanisms which could explain hypercalcemia in hyperthyroidism, but none can be accepted on the basis of available evidence. They speculate that

the factor of immobilization which, by itself, stimulates increased bone resorption could precipitate hypercalcemia, and this may have played a role in our second patient in whom symptomatic hypercalcemia occurred after he had been in skeletal traction for 17 days. Similarly, our fourth patient was at bed rest much of the time, and her hypercalcemia increased nine days after hospitalization. Calcitonin deficiency theoretically could produce hypercalcemia but no evidence exists for this. Furthermore, the fact that hypoparathyroidism is occasionally relieved by hyperthyroidism or thyroid hormone administration, plus the fact that myxedema markedly alters calcium metabolism, all show that thyroid hormone has definite direct effects on calcium metabolism.[1]

As a result of hypercalcemia and an increase in ionized calcium levels, parathyroid hormone secretion, as indicated by low serum immunoreactive parathyroid hormone levels, is suppressed,[21] and the tubular reabsorption of phosphate is increased so that serum inorganic phosphorus levels are usually normal. That this is not always so is shown by our first patient whose serum phosphorus level was often low. Anorexia and vomiting may lead to a low serum phosphorus in patients with thyrotoxic hypercalcemia either by reducing intake or by giving rise to hypokalemic nephropathy with impaired tubular reabsorption of phosphorus.[22] Hypercalcemia itself may be responsible for decreased tubular reabsorption of phosphate by an apparent direct effect on the renal tubule.[23] Since multiple factors may influence the tubular reabsorption of phosphorus, and hence the serum phosphorus level, it is not surprising that these parameters are not reliable indices of parathyroid function.[24]

An important diagnostic problem is presented when hypercalcemia, especially with hypophosphatemia, is found in the hyperthyroid patient because of the possible concurrence of primary hyperparathyroidism. Parfitt and Dent reported 23 cases of hyperthyroidism and coincidental primary hyperparathyroidism. They estimated that about 1 percent of patients with hyperparathyroidism have hyperthyroidism which may appear before, during, or after the hyperparathyroidism.[7] Whether or not this is a form of polyendocrine disease is debatable. Although hyperthyroidism has been reported in polyendocrine disease, it is uncommon,[25] and typical polyendocrine disease has not been seen in patients with hyperthyroidism and hyperparathyroidism.

There are three reports in which the hypercalcemia of hyperthyroidism was controlled by the use of glucocorticoids alone.[8,14,26] In two other cases,[27,28] a response to glucocorticoids occurred, but other measures such as hydration and antithyroid drugs were also employed. One widely quoted report notes the failure of thyrotoxic hypercalcemia to respond to glucocorticoids, but dosage and duration of therapy were inadequate (cortisone, 100mg daily for 6 days).[29] It appears that in most patients with thyrotoxic hypercalcemia, glucocorticoids will suppress hypercalcemia, so that such a response is strong evidence against associated hyperparathyroidism.

The correction of hypercalcemia by antithyroid treatment also excludes primary hyperparathyroidism and, apart from the determination of serum immunoreactive parathyroid hormone levels, is the best way to do so in most thyrotoxic hypercalcemic patients whose hypercalcemia is tolerably symptomatic or asymptomatic. In those with more severe hypercalcemia, a course of glucocorticoids will usually be therapeutically and diagnostically useful.

Finally, the presence of subperiosteal bone erosions on radiographs, is virtually diagnostic of primary hyperparathyroidism since this rarely, if ever, is seen radiographically, in hyperthyroidism.[2]

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(four cases) and non-functioning nerves due to section or pressure (four cases), we would obtain a real improvement rate of 82.1 percent (23 out of 28 cases), which is extremely remarkable particularly when one takes into consideration that these patients were "failures" of modern medicine and had received only a relatively brief course of acupuncture treatment.

From our follow-up study, it seems obvious that the pain relief was not sustained in a great majority of cases even though most of them had indicated to us that the degree of pain was tolerable. We believe that these patients should have a maintenance acupuncture treatment twice or once a week, gradually decreasing to once every other week, monthly, etc., depending on the patient's progress before the treatment is discontinued. In fact, this is what the Chinese do.

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The authors wish to acknowledge the assistance of Raphael C. Cilento, MD, in this research.

Symposium on Acupuncture

The American Journal of Chinese Medicine has announced that it will sponsor the Second World Symposium on Acupuncture and Chinese Medicine March 8-11 in San Francisco. The American Society of Chinese Medicine and the Acupuncture Research Institute are cooperating in the symposium.

For additional information about the scientific and training sessions planned for the symposium, contact the Office of the Editor, American Journal of Chinese Medicine, PO Box 555, Garden City, N.Y. 11530

Perinatal Tips

By Paul M. Zavell, MD
Detroit

The following case from the files of the Wayne County Medical Society Perinatal Mortality Study Committee is presented as an aid in continuing education.

Maternal

This was the third pregnancy for this 36 year old G III, P II (III) O Neg. white mother. Her first pregnancy ended successfully seven years ago and her second pregnancy three years ago. Both children are home alive and well. This pregnancy was without incident until one week before this admission. (She had been seen on a regular basis for prenatal visits from the second month on.) One week previously she came to the hospital in what turned out to be false labor. She was discharged home in 24 hours and at that time she noted the appearance of a few petechiae on her face and abdomen. On the day of this admission she had a large amount of epistaxis at home and sudden widespread generalized appearance of petechiae. She denied use of any drugs other than an occasional aspirin and a prescribed thiozide diuretic three weeks previously. She admitted use of tobacco only very rarely. She had no history of allergy or viral disease. After 18 hr. 49 min. of labor (1st, 18' 27"; 2nd, 17"; 3rd, 5") she delivered her third child, a son.

Upon admission, before, after delivery and until discharge 10 days later she was seen in consultation by two different internists (one interested only in hematology and one with a secondary interest in both hemotology and allergy) as well as by the chief pathologist of the hospital (who is considered an expert in hemotology). Multiple kinds and types of tests were performed, such as fibrinogen, PPT, Petechial counts, etc. She received the following therapy: 2 units of pack cells, 1 unit of frozen plasma and then 10 units of platelet concentrate. The lowest her platelets fell were to 6000/mm^3 but they gradually rose to 60,000/mm^3 by discharge. Perhaps the pathologist's summary from a sternal bone marrow test sums up this problem: "The combination of the markedly accelerate megakarocytogenesis in the light of a significant thrombocytopenia is consistent with the diagnosis of thrombocytopenia purpura of undetermined etiology. What part the thiozide diuretic played here could not be decided but probably was essentially quite unimportant."

Fetal

This 7 lb. 1 oz. white male infant delivered by spontaneous and apparently normal vaginal delivery appeared normal at birth except for a few scattered petechiae on the trunk. Cord blood was O negative with 2.5 mgm% bilirubin. The infant was seen by a pediatrician at five hours of age. By this time petechiae had increased noticeably all over the body but physical exam otherwise was normal. Laboratory tests done showed a hemaglobin of 22.8 gm, hematocrit of 66, WBC of 17,800 with a blood smear showing a great deficiency of platelets. During the next 10 hours petechiae increased dramatically over the body. At this time a platelet count was 19,000/mm^3 but two hours later this was repeated and reported then as being 6000/mm^3. Some of the lesions now looked like "large blueberries." Because it was feared the

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Doctor Zavell, MD is chairman of the Perinatal Mortality Study Committee, Wayne County Medical Society, and a member of the Neo-Natal and Hospital Care Committee Michigan Chapter American Academy of Pediatrics.

infant might bleed and because at this small hospital there was not at this time a ready supply of platelet concentrate and O negative blood the infant was transferred to Children's Hospital of Michigan. There he was seen in consultation by the hematology department. They confirmed the petechiae and felt the diagnosis was "neonatal thrombocytopenia purpura—idiophatic (?? secondary to thiozide administered to the mother)." The infant's course at Children's Hospital was essentially benign except that in the first 24 hours after admission he vomited coffee ground material on one occasion and by 48 hours after admission (three days of age) he had become jaundiced. Bilirubin was 14.7 (0.8 direct) mgm%. The infant was treated by phototherapy and oral glucose water between milk feedings. In the next 24 hours bilirubin fell to 10.5 mgm% (0.3 mgm% Direct).

During the Children's hospitalization multiple studies were done. These included CBCs, urinalyses, reticulocyte counts, daily platelets, immunoglobulins, bone marrow, viral cultures for rubella, cytomegalic, herpes and adeno group, skeletal x-ray survey. All these were essentially normal except for reticulocyte counts of 3.0 and 5.0%, daily and serial platelets of 7,000, 24,000, 30,000, 73,000 and 156,000/mm^3. Several fundoscopic exams failed to reveal hemorrhages of the retina. Bone marrow exam was reported as compatible with idiopathic thrombocytopenic purpura. At three weeks of age after an uncomplicated recovery the infant's platelet count was reported as 315,000/mm^3, Hgb of 18.0 mm and reticuloyte count of 0.1%.

Perinatal Committee Comments

1. Although neonatal thrombocytopenia purpura is a relatively rare condition, it does occasionally occur. Most cases seem to fall in the idiopathic group but known causes include infant infection (sepsis, syphilis, rubella, herpes simplex, cytomegalic inclusion disease, toxoplasmosis, etc.), drugs administered previously to the mother (especially thiozide diuretics), maternal systemic L.E., and in association with I.T.P. of the mother. Much rarer causes to be considered are secondary to exchange transfusion, inherited disease (Aldrich's syndrome), congenital leukemia and giant hemangioma.
2. Prognosis for the infant varies with the causes and the degree of thrombocytopenia present. If I.T.P. is present the course is usually mild and rarely needs specific therapy but the infant should be watched carefully as the danger of bleeding (especially intracranially) is always present.
3. Where a definite cause can be pinpointed, treatment of or elimination of the cause (i.e. infection) is just as important as treating the thrombocytopenia.
4. Diagnosing thrombocytopenic purpura without definite purpura by evaluation of the platelet count alone can by very questionable. Newborn premature (and some term) infants may have platelet counts normally in the 20,000/mm^3 range or lower.
5. Use of the bleeding and clotting time in thrombocytopenic purpura is to be discouraged for prolonged bleeding may result when the bleeding time is done and usually the clotting time is normal here despite continued bleeding.
6. The mother's thrombocytopenia in this case could not have been due to the thiozide diuretic she received. In such cases the maternal platelet count is normal (here it was markedly reduced.)
7. Suggested studies to be done initially are CBC and platelet count. If anemia is present this should alert one to possible blood loss or overwhelming infection. If leukopenia is present sepsis should be considered while if lecukocytosis is noted infection and congenital leukemia are possible. Perhaps most helpful initially is a platelet count to evaluate the infant properly.
8. Because of the multiple causes for neonatal T.P. use of a pediatric hematologist is strongly recommended. Proper use and interpretation of a bone marrow (especially the megakaryocytes) is most rewarding.
9. The committee commends both the obstetrician and the pediatrician here for each realizing their limitations in such a problem and wisely using proper consultants and hospital facilities.

Lead Levels in Urban Grand Rapids Children

By Robert G. Bulten, MD
John L. Doyle, MD
Donald G. Young, MD
Grand Rapids

Introduction

There has been much discussion in the medical literature as well as much political debate, in the last several years, about the need for screening programs for the detection of lead poisoning in children who live in high risk areas. Lead detection programs in several major cities have indicated that "10 per cent to 25 per cent of such children have evidence of undue absorption of lead, and 2 per cent to 5 per cent show evidence of poisoning."[1]

Despite the presence of high risk children (children between the ages of one and five years that live in housing constructed prior to World War II) in urban Grand Rapids with a total population of about 200,000 there has not been a recognized problem due to excess lead exposure in this area. This is substantiated by the fact that in the past eight years only 12 cases of lead poisoning have been diagnosed and recorded in the four major city hospitals' record departments.

Because of these facts and the knowledge that plumbism is recognized as a cause of death as well as severe brain damage and mental retardation among poisoned children, the following study was undertaken in an attempt to determine the extent of the problem in this community.

The authors are members of the medical staff of Butterworth Hospital, Grand Rapids.

Method

Between December, 1971, and April, 1973, 80 children were randomly selected for blood lead level determinations based on the following criteria: aged 12 months to 60 months and living in older or deteriorated housing in the inner city Grand Rapids. The children were primarily selected from the inpatient pediatric service at Butterworth Hospital. A few children were selected from various outpatient clinics. None was admitted with the diagnosis of lead ingestion or poisoning, and none presented or developed symptoms or signs suggestive of that diagnosis.

All patients had 5 cc of whole blood drawn into lead-free containers and blood lead levels were determined by atomic absorption spectrophotometry.

Parents or guardians of children with lead levels initially greater than 40 mcg/dl were notified to return to the laboratory for repeat determinations.

Results

Of the 80 children tested, the mean blood lead level was 26.5 mcg/dl and the median blood lead

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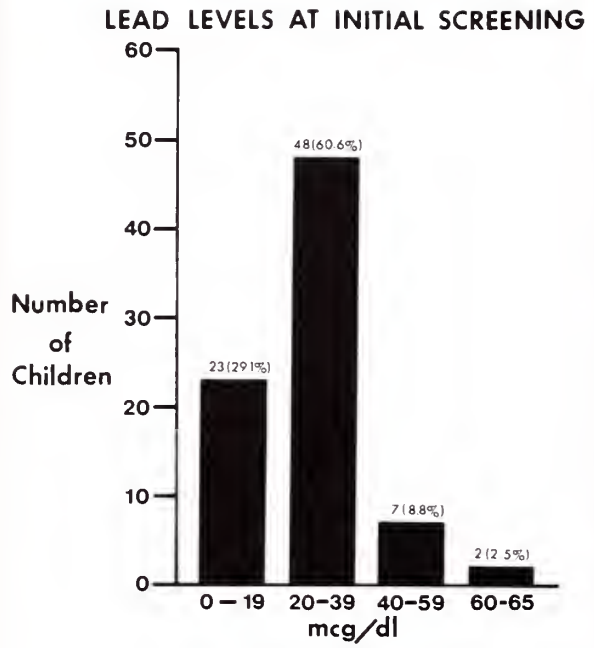

Table 1

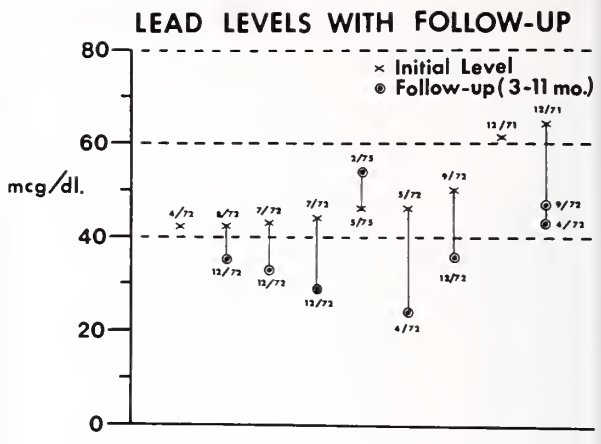

Table 2

level was 25.0 mcg/dl. There were nine children (11.3 per cent) with lead levels greater than 40 mcg/dl, and two (2.5 per cent) with lead levels greater than 60 mcg/dl. None was found with lead levels greater than 65 mcg/dl (*see Table I*).

Of the nine children with 40 mcg/dl or greater blood lead levels, seven returned for repeat determinations from three to 11 months after the initial level was obtained (*see Table II*). Of those seven, six (86 per cent) had a lower blood lead determination on repeat testing, and five of the seven (71 per cent) had repeat lead levels below 40 mcg/dl. Three (3.8 per cent of the original 80 children) still had lead levels between 40.0 mcg/dl and 60 mcg/dl, and one child (K. T.) could not be located for repeat determination.

Discussion

There are several methods described for screening for increased lead ingestion; among them are urinary coproporphyrins, hair and fingernail lead determinations, urinary excretion of delta aminolevulinic acid (ALA), and blood lead levels.[4] There has also been a recently described free erythrocyte prophyrin (FEP) test which is easy and economical, but has not been extensively evaluated.[6] Without obviously elevated blood lead levels and frank symptoms of plumbism, the value of the urinary determinations of coproporphyrins and ALA is questioned as a screening technique because of variation in urine concentration over a 24 hour period. The FEP determination correlates well with lead intoxication. Blood lead levels are felt to be the most reliable method available as a screen for increased lead ingestion and lead intoxication. However, isolated blood lead levels have the drawback of giving information at only one point in time and do not reflect the deranged body metabolism due to increased lead.

There is much debate as to what constitutes increased lead ingestion in the absence of signs or symptoms suggestive of lead poisoning. Jacobziner defined lead poisoning as a lead level of 60 mcg/dl or higher and the presence of two signs or symptoms of lead poisoning, including anorexia, anemia, pallor, irritability, stupor, lethargy, convulsions or x-ray evidence of lead flecks in the GI tract.[3] The United States Public Health Service defines any blood level greater than 40 mcg/dl as evidence of "undue absorption" of environmental lead, and blood lead levels greater than 80 mcg/dl as evidence of definite lead poisoning. Therefore, it is impossible to catagorically make the diagnosis of lead poisoning when the level lies between 40 mcg/dl and 60 mcg/dl, but there is some indication that there has been increased exposure and absorption of lead when the blood level is greater than 40 mcg/dl. There is no evidence to indicate,

however, that blood lead levels between 40 mcg/dl and 60 mcg/dl (in the absence of signs and symptoms of CNS involvement) have any deleterious effect on the normal growth, development or well being of a child.

There is a known seasonal variation on blood lead levels with the peak incidence between June and September. Unfortunately, only 18 out of our 80 (22 per cent) specimens were obtained during those months. Of those specimens which were greater than 40 mcg/dl, four of nine (44 per cent) were obtained between June and September. We may have found a higher incidence of elevated lead levels if more specimens had been obtained during the peak months. All eight repeat specimens were obtained during the October to May period.

One study done on 6,151 children in 14 Illinois cities (excluding Chicago) found 18.6 per cent of the children to have greater than 40 mcg/dl (with a city to city variation of 9.6 per cent to 31.3 per cent).[2] They also found that 0.8 per cent of the children tested had lead levels greater than 80 mcg/dl. This study was conducted during July to September, 1971. Results of repeated blood lead levels on those children initially found to have elevated levels were not published.

The incidence of lead poisoning in Grand Rapids is very low. Although our series is small and most of our lead levels were not obtained during months of peak reported incidence, no cases of seriously elevated serum lead were found in this at-risk population. Of those with lead levels in the "undue absorption" zone who were retested, 86 per cent (six of seven) had lower values and 71 per cent (5 of 7) had normal values up to 11 months later. The question must be raised as to the significance of a transient elevation of blood lead levels into the defined "undue absorption" range. Although these children represent the pool from which cases of chronic lead intoxication may evolve, our data suggest that the vast majority has but a transient increase in blood lead levels.

Summary

We found an incidence of 11.3 per cent of the children tested in inner city Grand Rapids to have blood lead levels greater than 40 mcg/dl, and 2.5 percent of those tested above 60 mcg/dl. None was found greater than 64 mcg/dl. Of the seven children with elevated blood lead levels who returned to have repeat determinations, six were lower, five being in the normal range three to 11 months following the initial determination with no specific treatment.

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Detroit Reports Increase in Child Lead Poisoning

Lead poisoning in children continues to be of concern to public health officials in many cities. The Detroit Health Department recently reported that a quarterly report covering July 1 through Sept. 30, 1973, showed the highest incidence of lead poisoning in pre-school children for any quarter to date in Detroit.

"Of 2,910 children under six years of age who were reached, 661 youngsters, or 22 per cent, had elevated lead levels in their blood," said William Clexton, DVM, Detroit public health director. "This is the highest percentage reported by the lead-poison control staff since the program began in July, 1972."

The average reported nationally is 4 per cent.

A preponderance of older homes in Detroit is one of the reasons given by the director for the extremely high percentage of lead poisoned children.

Members of the Council of Specialty Societies devoted their Nov. 28 meeting to workshop on Professional Standard Review Organizations with guest panelists providing background information.

Lee B. Stevenson, MD, of Farmington (right), who presided over the discussion, turns to confer with Martin Dale of the American Medical Association, who came from Chicago for the session.

Robert Goodnow from Region V of the Social Security Administration, Chicago, one of the guest panelists, turns his attention to a question.

Among specialty society representatives taking part in the session were (from left) Fredric Somach, MD, of Flint, of the Michigan Association of Neurological Surgeons; Thomas C. Payne, MD, of Lansing, Michigan Radiological Society; Robert E. Burns, MD, of Detroit, of the Michigan Dermatological Society; Jerome S. Kozak, MD, of Lansing, of the Michigan Orthopaedic Society, and Robert L. Vitu, MD, of Saginaw, of the Michigan Academy of Family Physicians.

Specialties Council Studies Government Impact on Medical Practice

The Council of Specialty Societies devoted its last meeting of 1973 to a workshop session on Professional Standards Review Organizations. The workshop was held in the MSMS Headquarters in East Lansing with Glenn E. Moore, MD, of Flint, council moderator, opening the program.

Lee B. Stevenson, MD, of Farmington, presided over the discussion led by Martin Dale from the American Medical Association; Robert Goodnow, from Region V of the Social Security Administration in Chicago; Richard Campau of the MSMS staff, representing the MSMS Committee on PSRO Activity, and Donald C. Smith, MD, director of the Governor's Office of Health and Medical Affairs.

Donald C. Smith, MD (left), director of the Governor's Office of Health and Medical Affairs, was among panelists at the meeting chaired by Glenn E. Moore, MD (right), moderator of the Council of Specialty Societies.

Among panel members were (from left, across table) Richard Campau of the MSMS staff, Robert Goodnow of the Social Security Administration, Martin Dale of the American Medical Association and Lee B. Stevenson, MD, moderator for the discussion.

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Jan. 15—Midwinter board meeting, MSMS Auxiliary, at MSMS headquarters, East Lansing, contact; Mrs. William J. Jones, president, 15839 Crescent Dr., Allen Park, Mich. 48101.

Jan. 16—Lecture on acupuncture by William M. Lukash, MD, White House physician, sponsored by William Beaumont Hospital Research Institute, at the hospital in Royal Oak, contact: Research Institute, Beaumont Hospital, 3601 W. 13 Mi. Rd., Royal Oak, Mich. 48072.

Jan 21-25—Family practice review, sponsored by the Michigan Academy of Family Physicians, University of Michigan, Ann Arbor, contact: MAFP office, 933 Wing St., Plymouth, Mich. 48170.

Jan. 25-26—Postgraduate education course on "Colon Disease & Colonoscopy," offered by the Medical College of Wisconsin, departments of gastroenterology and surgery, at Milwaukee's Pfister Hotel, contact: Joseph E. Geenen, MD, 8700 W. Wisconsin Ave., Milwaukee, Wis. 53226.

Jan. 26-27—Midwinter seminar, American Association of Medical Assistants, State of Michigan, Holiday Inn, Port Huron, contact: Judy Cogley, 1529 Wells St., Port Huron, Mich. 48060.

Jan. 30—MSMS Council, MSMS headquarters, contact: Warren F. Tryloff.

Jan. 30-31—Postgraduate course on "Medical Progress for the Family Physician," sponsored by the Cleveland Clinic Educational Foundation, in Cleveland, contact: Linda L. Bitonti, Education Secretary, the Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland, Ohio 44106.

Feb. 6-7—Postgraduate course on "Current Topics in Blood Banking," sponsored by the Cleveland Clinic Educational Foundation, in Cleveland, contact: Linda L. Bitonti, Education Secretary, the Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland, Ohio 44106.

Feb. 6-8—Western Michigan Conferences on Diagnostic Techniques, sponsored by the Nuclear Medicine Department of Hackley Hospital, Muskegon, Central Chapter of the Society of Nuclear Medicine and Nuclear Medicine Department, University of Minnesota Hospital, Minneapolis, at the Holiday Inn, Petoskey, contact: James C. Carlson, Nuclear Medicine Department, Hackley Hospital, Muskegon, Mich. 49443.

Feb. 9—Seminar on "Diseases of the Thyroid," sponsored by the Michigan Society of Pathologists, at Henry Ford Hospital's auditorium, Detroit, contact: Jacob E. Briski, MD, St. John Hospital, 22101 Moross Rd., Detroit, Mich. 48236.

Feb. 13—Surgical symposium, sponsored by the Lansing Obstetrical/Gynecological Society and Edward W. Sparrow Hospital, at the Kellogg Center, Michigan State University, East Lansing, contact: Sparrow Hospital Education Department, 1215 E. Michigan Ave., Lansing, Mich. 48912.

Feb. 21-24—Seminar and ski weekend arranged by the Continuing Post Graduate Psychiatric Education Program at Wayne State University, at Shanty Creek Lodge, Bellaire, for physicians and spouses, contact: Leon E. A. Berman, MD, Detroit Psychiatric Institute, 1151 Taylor Ave., Rm. 151 B, Detroit, Mich. 48202.

Feb. 28-March 1—Postgraduate seminar, International Medical Assembly of Southwest Texas in San Antonio, contact: S.E. Cockrell, Jr., executive director, IMAST, 202 W. French Pl., San Antonio, Texas 78212.

March 7—Professional Activity Study and Medical Audit Program Institute, sponsored by Commission on Professional and Hospital Activities, at CPHA headquarters, Ann Arbor, AAFP elective hours, contact: CPHA, 1968 Green Rd., Ann Arbor, Mich. 48105.

March 13—MSMS Council, MSMS Headquarters, contact: Warren F. Tryloff.

March 14-15—23rd annual postgraduate course in pediatrics, University of Texas Medical Branch, Galveston, contact: Lillian H. Lockhart, MD, Department of Pediatrics, University of Texas Medical Branch, Galveston, Texas 77550.

March 15-16—Second Annual National Conference on Human Nutritional Aspects of Kidney Disease and Renal Failure sponsored by the Kidney Foundation of Michigan, Michigan Renal Dietitians and the Michigan State University School of Nutrition, at Kellogg Center, MSU, East Lansing, contact: Ms. Jean Bruge, Michigan Nephrology Center, Borgess Hospital, 1521 Gull Rd., Kalamazoo, Mich. 49001.

March 18-21—Physician postgraduate course "Rheumatic Disease: Pathogenesis, Diagnosis and Treatment," sponsored by American Col-

lege of Physicians, at U-M Medical Center, Ann Arbor, contact: ACP, 4200 Pine St., Philadelphia, Pa. 19104.

March 18-23—Continuing education course in laryngology and bronchoesophagology, sponsored by the Department of Otolaryngology, Abraham Lincoln School of Medicine, University of Illinois, and the Eye and Ear Infirmary, U of I Hospital, in Chicago, contact: Dept. of Otolaryngology, Eye and Ear Infirmary, 1855 W. Taylor St., Chicago, Ill. 60612.

March 27-28—Annual Michigan Conference on Maternal and Perinatal Health, the Pantlind Hotel, Grand Rapids, contact: Lloyd Kammeraad, MD, 1810 Wealthy St., SE, Grand Rapids, Mich. 49506, or Helen Schulte, MSMS Headquarters.

March 31-April 6—Introductory course in "Functional Corrective Surgery of the Nasal Septum and the External Nasal Pyramid," "Rhinomanometry and Naso-antral Manometry" and "Basic Principles of Respiratory Physiology and Fundamental Diagnostic Tests," sponsored by the American Rhinologic Society and the Illinois Masonic Medical Center, Chicago, at the center, contact: R.P. Gustafson, Illinois Masonic Medical Center, 836 Wellington Ave., Chicago, Ill. 60657.

April 4—Ninth Annual Conference on the Medical Aspects of High School Sports, sponsored by MSMS, at Towsley Center, U-M, Ann Arbor, contact: Helen Schulte, MSMS Headquarters.

April 24—Annual Legislative Day, MSMS Auxiliary, at Olds Plaza Hotel, Lansing, contact: Mrs. Robert J. Westerhoff, 2458 Maplewood, SE, Grand Rapids, Mich. 49506.

April 24-25—Annual Spring Conference, MSMS Auxiliary, at Hospitality Inn, Lansing, contact: Mrs. William J. Jones, president, 15839 Crescent Drive, Allen Park, Mich. 48101.

April 25-27—27th National Conference on Rural Health sponsored by the AMA Council on Rural Health at the Detroit Hilton Hotel, contact: Bond L. Bible, PhD, Department of Rural Health, AMA, 535 N. Dearborn St., Chicago, Ill. 60610.

April 25-28—Annual convention, American Association of Medical Assistants, State of Michigan, Detroit Hilton Hotel, contact: Virginia Doyle, 1484 Southfield Rd., Birmingham, Mich. 48009.

May 1-3—Annual meeting of the Michigan Public Health Association, Detroit Hilton, contact: Anna Lampela, MPHA, 403 Seymour Ave., Lansing, Mich. 48914.

May 2-3—Annual session and scientific program, Michigan Heart Association, Cobol Hall, Detroit, contact: Michigan Heart Association office, 16310 12 Mile Rd., Southfield, Mich. 48076.

May 5—MSMS Council, Boyne Falls, contact: Warren F. Tryloff.

May 5-7—1974 Annual Session, MSMS House of Delegates, at Boyne Mountain Lodge, Boyne Falls, contact: Richard Campau, MSMS Headquarters.

May 9-10—Seventeenth Annual Clinic Days of Children's Hospital of Michigan, postgraduate meeting on pediatric infectious diseases, cosponsored by the Wayne State University School of Medicine, contact: Adnan Dajani, MD, Children's Hospital of Michigan, Detroit Medical Center, 3901 Beaubien Blvd., Detroit, Mich. 48201.

June 12—MSMS Council, MSMS Headquarters, contact: Warren F. Tryloff.

June 16-27—1974 Summer Program in Human Sexuality, sponsored by the Indiana University Institute for Sex Research, in Bloomington, Ind., contact: Institute for Sex Research, 416 Morrison Hall, Indiana University, Bloomington, Ind. 47401.

July 6-10—Michigan Academy of Family Physicians Annual Meeting and Scientific Program, Park Place Motor Inn, Traverse City, contact: MAFP office, 933 Wing St., Plymouth, Mich. 48170.

July 22-24—Ninth annual continuation course in "Current Practice of Clinical Electroencephalography," sponsored by the American Electroencephalographic Society, in Seattle, Wash., contact: Donald W. Klass, MD, Mayo Clinic, Rochester, Minn. 55901.

July 31-Aug. 1—MSMS Council, St. Clair Inn, St. Clair, contact: Warren F. Tryloff.

Sept 23-27—Family practice review, sponsored by the Michigan Academy of Family Physicians, at Scott Hall, Wayne State University School of Medicine, contact: MAFP office, 933 Wing St., Plymouth, Mich. 48170.

Sept. 25—MSMS Council, MSMS Headquarters, contact: Warren F. Tryloff.

Oct. 9-10—109th Scientific Session, sponsored by MSMS, at the Sheraton-Cadillac Hotel, Detroit, contact: Helen Schulte, MSMS Headquarters.

Nov. 6—MSMS Council, MSMS Headquarters, contact: Warren F. Tryloff.

Dec. 11—MSMS Council, MSMS Headquarters, contact: Warren F. Tryloff.

Mediscene each month lists upcoming meetings in Michigan or, if out of state, of special interest to Michigan physicians. Please submit meeting notices for listing at least two months prior to meeting dates to ***Michigan Medicine,*** 120 W. Saginaw St., East Lansing, Mich. 48823.

Socio-Economic

Here are Questions and Answers on Phase IV Economic Controls

Changes in federal economic controls over medical practitioners spelled out by the Cost of Living Council became effective Jan. 1 and permit physicians to increase fees by 4 per cent, with certain limitations.

Following are questions and answers about the new control system.

Question: How does the new control system for medical practitioners differ from the Phase II/III regulations for non-institutional providers of health services?

Answer: The system:

1. eliminates cost justification as a requirement for price increases;
2. increases the aggregate annual weighted price increase limit from 2.5 per cent to 4 per cent and places a 10 per cent limit on the permissible price increases for any service over $10 and a $1 increase for services under $10;
3. allows aggregate weighted price increases to be determined using weights based on the previous calendar year's billings rather than projected volume of services;
4. shortens the length of time a profit margin test is in effect following a price increase.

Question: Is posting a requirement under Phase IV regulations?

Answer: Yes. Each practitioner is required to post an easily readable sign stating the availability of his price schedule.

Question: What information is required on a medical practitioner's price schedule?

Answer: The price schedule must show the prices in effect Oct. 1, 1973, for those services which comprised 90 per cent of total revenues in the last calendar year. It must also contain any subsequent change in any of these prices, the date of each price change, and the weight given to the service in determining the total aggregate weighted price increase.

Question: A practitioner charges different fees for the same service offered to different classes of patients. Is he required to list each fee on his price schedule?

Answer: Yes, each different fee to different classes of patients should be shown on the price schedule.

Question: Are medical practitioners subject to any prenotification or reporting requirements?

Answer: No, with one exception. The only such requirement is for a practitioner moving to a new location within 50 miles of his old location. If prevailing rates are higher in the new location and the practitioner therefore wishes to raise his fees, he must obtain prior approval from the Cost of Living Council before raising his fees above the usual limits.

Question: Are physicians still entitled to take the price increases accumulated during Phase II and III? May they continue to accumulate unused price increases in the future?

Answer: Allowable price increases not taken in 1972 and 1973 may still be taken at any time now or in the future. These must be cost justified in accordance with Phase II and III regulations. Price increases not taken under revised Phase IV regulations in 1974 may also be accumulated. However, when using accumulated price increases, the 10 per cent limitation on price increases for any service in any calendar year does apply.

Question: Are cost increases required to justify price increases under revised Phase IV regulations?

Answer: No. Cost justification is no longer required.

Question: In determining a practitioner's profit margin, should the fees charged or the monies actually received be used for calculations?

Answer: Profit margins may be determined by using either the aggregate of billed charges or monies received (which excludes bad debts) as long as the determination is consistent with the accounting practices previously used within a practice.

Question: If a physician works longer hours or increases productivity through improved efficiency or use of more paramedical assistants, may he increase his profit margin without going through the exception process?

Answer: Yes, as long as prices are not increased, a practitioner's profit margin is unrestricted.

Question: If a practitioner increases prices, for how long will he be subject to the profit margin restriction?

Answer: If prices are increased during the first quarter of a practitioner's fiscal year, the profit margin restriction will apply only to that year. If prices are increased after the first quarter, the profit margin restriction will apply to that year and to the next year.

Question: Are new services provided by medical practitioners included within the 4 per cent limitation?

Answer: No. When the practitioner provides a new service or property which he did not provide in the same or substantially similar form at any time during the preceding one year period, he may establish a base price comparable to the prices charged for that service by other providers in the same medical market area.

Question: If a practitioner has substantially renovated his office in order to provide patients with better quality care, is he now providing new services?

Answer: No. Since the same services are being provided after the office renovation, they are not considered to be new services. Fees may be increased beyond the allowable limit only on an exception basis. Exceptions to recover cost increases may be granted if it is felt that there has been a significant and substantial increase in the quality of a service and the physician would otherwise experience a decline in his profit margin.

Question: What restrictions apply to the wage increase which may be given to employees of a medical practitioner?

Answer: Employees within the health industry continue to be subject to the 5.5 per cent limit on salaries and .7 per cent limit on fringe benefits.

Question: A physician or dentist is just starting a new practice. What restrictions are there on his fee schedule?

Answer: New practitioners may establish fees for their services which do not exceed the prices received for those services by a substantial number of other practitioners in the same marketing area.

Question: An established physician plans to join with two other physicians in a group practice. How do they establish their fees and base period profit margin?

Answer: Each practitioner may choose to retain, as separate fee schedules, his established fees. As an alternative, practitioners may adopt a standard fee schedule by charging the highest price for each service, at or above which, at least 40 per cent of those services were priced by the members of the group during the immediately preceding calendar year (i.e., 60th percentile of charges). Base period profit margin should be recomputed by combining aggregate annual revenues and operating expenses for all practitioners during the base years.

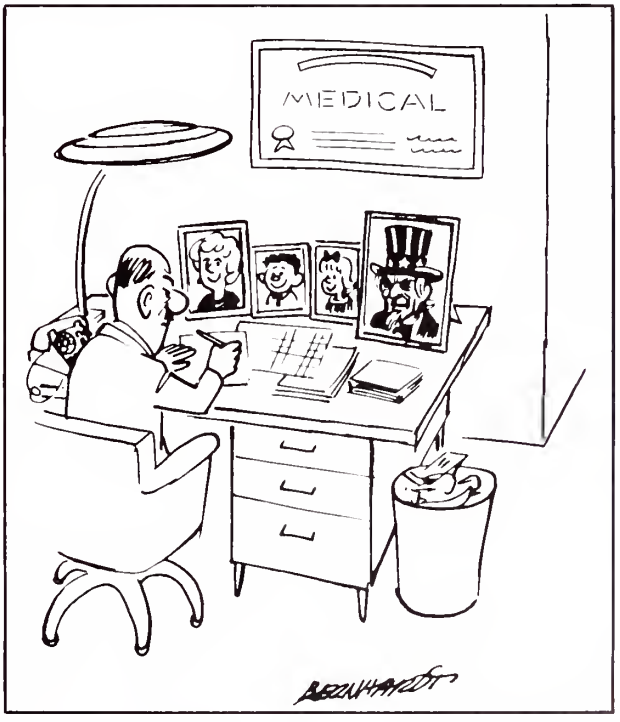
Question: A physician plans to leave his group practice of three physicians and set up a solo practice in the same community. How does he establish his new fees and base period profit margin?

Answer: The fees and base period profit margin established in a group practice are retained by any member leaving the group unless the physician moves to a new market area with higher prevailing rates.

Question: How is a hospital-based pathologist with a percentage-of-net contract restricted by new Phase IV price regulations?

Answer: The pathologist's "price" is defined to be the revenue received for each service performed or product provided by his department. This "price" is subject to all the provisions of the revised Phase IV regulations. If the hospital does not raise its prices for that department, the per cent of the net contract may be increased 4 per cent. If the hospital raises its prices in that department by more than 4 per cent, the pathologist may receive only an additional 4 per cent aggregate weighted revenue for each unit of service or product.

These questions and answers were taken from material provided by the Cost of Living Council.



Society Needs New Efforts by Physicians and Philosophers, Says MSU Medical Dean

Threatened dehumanization of medicine must be met by new philosophical approaches that may be applicable to the effects of technology on society as a whole, according to Andrew D. Hunt, Jr., MD, dean of the College of Human Medicine at Michigan State University. In an address at MSU's fall term graduate commencement ceremony Dec. 1 in East Lansing, Dean Hunt briefly reviewed the history of university-based medical education and turned attention to the role of humanities in the training of physicians. The text of his address follows.

Health has reached the status of being the nation's second or third largest industry. Hospital affairs, including such issues as expansion, retrenchment, and cooperation, involving as they do a considerable segment of the community's resources and pride, often become emotional in the extreme. Maldistribution of physicians and other health professionals is a major social and economic problem, and the high cost of health care, in the eyes of many, approaches scandal, or perhaps even calamity. Finally, the high income level of many physicians, in the eyes of some, contaminates the normal relationship between a normally empathic and altruistic profession and its public.

These issues between the health professions and society likewise operate to contaminate the relationship between medical schools and their universities, and each of the issues just related finds its counterpart in universities. Indeed, the very viability of this and other health profession education in the confines of the university is often questioned. It should be added that medical faculties themselves sometimes question the rationality of working within a system of constraints, restrictions, procedures and bureaucratic behavior which is uncharacteristic of most of the world of medical care with which they and their practicing colleagues are familiar.

Since you are about to become alumni, and as such cannot escape from the affairs of your university, I will take this opportunity to discuss with you the historical rationale for a university base for medical education, to describe briefly for you arrangements for medical education on this campus, and finally to say something about the future.

In Europe, ever since the Middle Ages, medicine has been a major university discipline. Indeed, until relatively recently, medicine, law and divinity were the three major segments of the European university.

Modern medical education probably began in Leiden, Holland, with Hermann Boerhave, who, in about 1700, established the first university hospital consisting of twelve beds wherein clinical teaching became integrated with sciences basic to medicine. Boerhave, a man of great genius and learning, who simultaneously held professorships of chemistry, botany, and medicine, attracted scholars from all over Europe and the British Isles. One of these, a Scotsman, eventually migrated to the United States, and was one of the founders of the first medical school here at the University of Pennsylvania. In Europe today, as in earlier times, the faculty of medicine is an integral part of a great majority of significant universities and accepts students immediately after graduation from secondary school, as do such faculties as philosophy and science.

The European tradition, then, became established early in the United States. Such universities as Pennsylvania, Harvard and Michigan supported medical schools on their campuses. In cases such as Pennsylvania and Michigan, the institutions developed their own university hospitals for research and education.

During the 19th century, proprietary medical schools, organized and dominated by practicing physicians and totally separate and independent from universities, grew in number, and in about 1900 there were over one hundred such schools. The Carnegie Foundation, in 1908, charged Mr. Abraham Flexner with the task of reviewing medical schools in the United States and Canada, and making recommendations. He found the proprietary schools grossly wanting at all levels, but especially in scientific and laboratory areas, and recommended in 1910 that all such institutions should either be closed or moved to university campuses. A few non-university medical schools survived the impact of this report, but the vast majority did not, and with extremely few exceptions medical education became the exclusive

prerogative of the universities. Indeed, in Michigan, guidelines were developed by the State Board of Education in 1969, requiring medical schools in this state to be established only in institutions with appropriate undergraduate and graduate programs in the sciences basic to medicine.

I will not belabor you with an involved history of medical education on the Michigan State University campus; I would simply point out that it has been developed with maximal integration and collaboration with the rest of the University in mind. Existing all-university departments in the traditional basic sciences of medicine became jointly administered with the new College of Human Medicine. Furthermore, the fundamental nature of the behavioral and social sciences to medicine was also recognized and certain departments in those disciplines became involved, in ways identical with the arrangements for the traditional basic sciences.

Twenty-eight per cent of our budget is currently invested in these jointly administered departments, only a few percentage points less than that which we put into our departments solely administered by us. Almost 3 million dollars of new research in 1973-74 alone has been generated by new faculty or new programs coincident with the development of this college, and $610,000 or 20 per cent of this amount resides in these preexisting jointly administered all-university departments.

Our new clinical departments, in almost every case, have faculty members with joint appointments in existing all-university departments. Furthermore, relationships with multiple colleges, in addition to natural science and social science, have been generated not only for more effective teaching, but also for research and demonstrations in such fields as education itself, improvement of medical care, computers as they relate to health services delivery, and child development. Various kinds of relationships, then, exist with the School of Nursing and such colleges as Agriculture, Veterinary Medicine, Osteopathic Medicine, Human Ecology, Education and Engineering.

A brief word about our curriculum is probably appropriate, since it is unusual, and has derived from the multiple inputs which these kinds of administrative arrangements have facilitated. It is basically oriented around self-learning, rather than faculty teaching, with the idea that much learning can take place by students in small groups if objectives are appropriately defined and evaluation instruments well designed and applied. The goal is to decrease unhealthy interstudent competition which, we feel, is not compatible with the sharing behavior characteristic of good medical care. Our utilization of community resources and community hospitals in many cities of the state has been developed to insure that students learn

Dean Hunt

about medicine and health problems as they really are, and we hope that such experiences will lead to more than the usual number of graduates eventually going into areas of need in Michigan. Finally, we are attempting to establish flexibility. The partial success of this effort is demonstrated by some students receiving their MD degrees at this commencement after 3½ years of study in a program normally requiring four years.

Contemplation of the future, in my mind, requires mind stretching which to some may appear far-fetched. Society is face to face with a situation which was described and predicted by authors such as Lewis Mumford; namely whether or not we will be able to utilize and control the proliferation of technology in the interest of the welfare of this planet, or whether man will be victimized by his own creations.

Medicine, and by medicine I here refer to all the health professions, is perhaps unique in this society, having been charged and mandated, to use all available resources in the interest of health care demands; whether on an individual basis in doctor-patient relationships, or in a larger societal framework such as in a Department of Public Health.

Now, medicine, with the rest of society, finds itself in danger of being overwhelmed by its own technological advances. Effective humanistic patient oriented care can easily be subverted to that which is dominated by cardiac monitors, dialysis machines and the overwhelming costs of application of technological modalities. In the absence of the greatest care, such efforts can not only be dehumanizing but disappointingly ineffectual in significantly either prolonging or enriching human life. How can we prevent important data bases for public health effectiveness, ever more efficiently and accurately stored in errorless computers, from becoming instruments of surveillance of human behavior, instruments for control of society rather than for its increased health and welfare?

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Production of Quality Drug Products Demands Never Ending Attention

By Claude V. Timberlake, RPH
Vice President, National
Pharmaceutical Council, Inc.
Washington, D.C.

Probably one of the least understood and appreciated areas in the health care field today involves the day-to-day production of pharmaceutical products used by physicians and others for the prevention, treatment and cure of the many heretofore fatal or crippling diseases.

The manufacture of drug products of high quality is a comprehensive and complex process requiring specialized personnel, technology and equipment seldom appreciated or even known of by prescribers and consumers of these valuable adjuncts in the practice of medicine. They are, for the most part, taken for granted.

I served for over 25 years as a pharmacist in the medical service corps of the navy, much of which time was spent participating in the development of a quality assurance program for the procurement of pharmaceutical products on a competitive bid basis for the Department of Defense. During this time, I developed a keen insight into, and appreciation for, the enormous number of factors necessary for the production of pharmaceutical products which consistently produced the desired results when they were administered to patients.

Combined Skills Needed

The manufacture and distribution of quality pharmaceutical products does not just happen. It requires the combined skills of many experts in the fields of pharmaceutical and medical technology. Total quality control must begin when the raw material enters the receiving department of the manufacturer and continue on a carefully planned and precisely executed step by step basis to the finished product. At every level of manufacture, the expertise of all personnel involved in the production of the finished dosage form must be of the highest caliber. Even the janitors, who keep areas clean, are especially trained to carry out their responsibilities. In short, the most important and indispensable element in the production of pharmaceutical products is people, extensively and intensely trained and dedicated to their respective roles.

During my career in the navy, I had the opportunity to see literally hundreds of thousands of pharmaceutical products produced by large and small manufacturers all over the United States and most of Europe. This was the result of a public law which, with minor exceptions, requires that the Department of Defense purchase its medical supplies, including pharmaceutical products, on a competitive bid basis. This means that anyone may bid on any product and that the procurement agency must buy from the lowest bidder meeting precise specification requirements on a specified delivery date. Among the most important of the numerous factors which are involved prior to making a decision to award a contract is a detailed inspection of the bidders' facilities, including analysis of qualifications of key personnel; analysis of production and quality control records, quality control procedures in effect and past performance records for the specified item or similar products. The pre-award facility surveys have, over the years, consistently shown that 40 to 50 per cent of the lowest bidders fail to comply with the good manufacturing practices as set forth by the Defense Department. Manufacturers failing these surveys are therefore rejected as suppliers for that particular award. Of the 50 to 60 per cent who do comply with the good manufacturing practices, 50 to 55 per cent of the pre-award samples they submit fail to meet specifications. Further, many of the manufacturer-supplied certificates of analysis of the products submitted do not accurately reflect findings upon detailed government laboratory analysis.

This paper was presented as part of a panel discussion on "Quality Drug Product Production" Oct. 11, 1973, during the MSMS Scientific Session. It has been edited for publication.

Full Time Inspector

After the contract has been awarded on the basis of the facility inspection and analysis of the pre-award samples, sampling criteria may require laboratory analysis and in some cases in vivo tests of each lot or batch of material to be delivered. On many contracts with firms which may be supplying a product difficult to produce, or a firm which may be producing the product for the first time, a government inspector will be assigned to spend full time in the plant while the material is being produced. This is particularly true when large contracts are awarded to foreign manufacturers where it is not practical to have an inspector drop in at frequent intervals to determine that production is on schedule and that all provisions of the contract are being complied with.

There also exists a procedure by which material that is not considered satisfactory when put to actual use in the field, is promptly reported to the defense medical material board and the procurement agency. The material is withheld from issue and use until a comprehensive analysis has been completed and the difficulty resolved. In most cases, a strengthening of the specification and more intensive testing prior to acceptance often results in the elimination of similar complaints on that item in future procurement.

Perhaps you may wonder which drug products presented problems. Prior to implementation of some of the quality assurance procedures which are in effect today, we encountered problems at one time or another with every item we attempted to purchase. That is not to say that substandard material always got into the supply system; most of it was stopped at the inspection and testing stage. However, some did reach patients before it was discovered to be faulty. Some examples which were stopped by testing samples included tablets of different products which simply failed the tablet disintegration tests in simulated gastric juice, injectables which were found to be non-sterile when submitted to sterility tests, intravenous solutions which contained particulate matter later determined to be glass particles which flaked off during the process of heat sealing the ampules, water for injection in hermetically sealed containers containing dead flies, penicillin injection contaminated with insect parts such as wings and legs, sterile gut sutures sealed in high flash naphthalene with numerous fleas also sealed in, ferrous sulfate tablets which exploded in the bottles, plus thousands of samples which did not contain the required amount of active ingredient. For a number of years we kept such samples as a constant reminder to keep up our guard against permitting the introduction of inferior drug products into the military medical supply system.

More Serious Failures

These are only a few examples but they will give you some idea of the problem. Of course, more serious failures are those which slip through the inspection procedures and fail to perform when administered to the patient. A few examples are:

> Diphenylhydantoin sodium, thyroid tablets, tetracycline, oxtetracycline, sulfisoxisole, procaine penicillin, surgical lubricant, surgical detergent, reserpine, methenamine mandelate and more recently spironolactone, digoxin and nitrofurantoin.

Of course, these products were those of the "lowest responsible-responsive bidders." Rarely did we encounter difficulty with items supplied by the innovators or the reliable, and experienced nationally known manufacturers. They simply had too much at stake to take chances on supplying inferior products. The substandard items which were discovered in laboratory tests, of course, never reached our military patients to cause harm. We had no way of knowing, however, how much of this rejected material subsequently reached the civilian market.

In a brief discussion, it would be impossible to go into the details involved in the development and implementation of a quality assurance program which the Department of Defense has developed over a period of some 25 years to assure that only high quality pharmaceutical products enter the military medical supply system. These purchases now are about $125,000,000 annually. There are, however, certain medicinal products which defy attempts to prepare specifications which consistently assure therapeutically and chemically acceptable products from multiple sources of supply. In these cases, regulations do permit a professional decision by the surgeons general of the army, navy and air force to specify that only the product as produced by a single manufacturer is acceptable for use. The Defense Department, with its long experience in the procurement of quality pharmaceuticals, attempts to assure chemical equivalency only. Even the Defense Department, with its resources and personnel, has not undertaken or attempted to assure therapeutic equivalency in drug products from multiple sources of supply.

Effective System

Obviously, however, the system must be effective when, as in 1970, it permitted only one drug product to enter the military medical supply system during the entire year which was recalled by FDA, while the total drug recalls by FDA during that same period was 951. This is not an isolated case. A comparison of FDA recalls with those of the military will reveal a similar proportion of recalls year in and year out. It may be a fair question to ask, who is receiving the medicinal products which have been found unsatisfactory for use by the military?

(Continued on Page 45)

The irritations of man's day are often reflected in his gut.

The causes of irritable colon and the diarrheal symptoms that often accompany it can be as diverse as the systemic and emotional irritations man is faced with daily.

Although the mucoid nature of stools and the occurrence of diarrheal episodes coincident with times of emotional stress may be valuable clues to the functional nature of the disorder, irritable colon must often be diagnosed by exclusion. Such diagnostic exploration takes time. Discovery of the nature of any emotional problems may take more. During that time, Lomotil® is an ideal agent for controlling diarrheal symptoms.

Lomotil tablets are small, easy to carry and easy to take. They act promptly and effectively. Secondary effects are relatively infrequent and, once the first force of the diarrhea is controlled, maintenance is frequently effective on as little as one fourth of the initial dosage.

These same characteristics make Lomotil useful in controlling the diarrhea associated with gastroenteritis, antibiotic therapy and acute infections.

Lomotil®

TABLETS/LIQUID

Each tablet and each 5 ml. of liquid contain:
diphenoxylate hydrochloride . . . 2.5 mg.
(Warning: May be habit forming)
atropine sulfate . . . . . 0.025 mg.

takes care of the gut issue in irritable colon

IMPORTANT INFORMATION: *This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL* IS NOT *AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.*

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

Dosage and administration: ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid,* 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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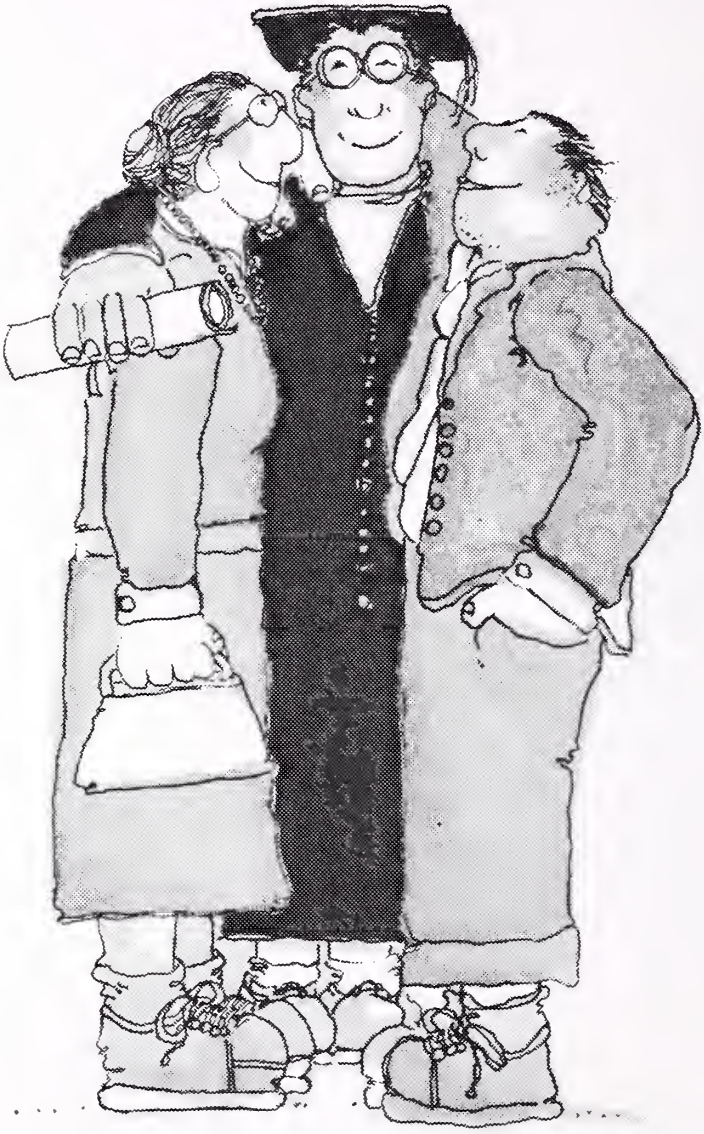

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(sodium dextrothyroxine)

Once-a-day dosage.

See reverse side for full prescribing information and dosage schedule.

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Choloxin® (sodium dextrothyroxine)

The Lipid-Lowering Agent with Once-A-Day Dosage

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AN IMPORTANT NOTE:
It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

CHOLOXIN® (sodium dextrothyroxine) Single-Tablet-A-Day Dosage Schedules

See prescribing information in package insert reproduced below.

	Starting Dosage	Increased by Increments of	Usual Maintenance	Maximal Recommended
Adult Hypercholesterolemic	1.0-2.0 mg.	monthly 1.0-2.0 mg.	4.0-8.0 mg.	4.0-8.0 mg.
Pediatric Hypercholesterolemic	0.05 mg./kg. body weight	monthly 0.05 mg./kg.	0.1 mg./kg. body weight	4.0 mg.
Hypothyroid Cardiac Patients	0.5-1.0 mg.	monthly 1.0 mg.	4.0 mg.	4.0 mg.

Choloxin®
(sodium dextrothyroxine)

Description
CHOLOXIN (sodium dextrothyroxine) is the sodium salt of the dextrorotatory isomer of thyroxine. It is chemically described as D-3,5,3',5'-tetraiodothyronine sodium salt.

Actions
The predominant effect of CHOLOXIN (sodium dextrothyroxine) is the reduction of serum cholesterol levels in hyperlipidemic patients. Beta lipoprotein and triglyceride fractions may also be reduced from previously elevated levels.

Most of the available evidence indicates that CHOLOXIN stimulates the liver to increase catabolism and excretion of cholesterol and its degradation products via the biliary route into the feces. Cholesterol synthesis is not inhibited and abnormal metabolic end-products do not accumulate in the blood.

Indications
This is not an innocuous drug. Strict attention should be paid to the indications and contraindications.

CHOLOXIN (sodium dextrothyroxine) is an antilipidemic agent used as an adjunct to diet and other measures for the reduction of elevated serum cholesterol (low density lipoproteins) in euthyroid patients with no known evidence of organic heart disease.

The drug is also indicated in the treatment of hypothyroidism in patients with cardiac disease who cannot tolerate other types of thyroid medication.

Before prescribing, note the following: Results from a randomized clinical study have indicated a possible adverse effect when CHOLOXIN is administered to a patient receiving a digitalis preparation. There may be an additive effect. This additive effect may possibly stimulate the myocardium excessively in patients with significant myocardial impairment. CHOLOXIN dosage should not exceed 4 mg per day when the patient is receiving a digitalis preparation concomitantly. Careful monitoring of the total effect of both drugs is important.

It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

Contraindications
The administration of CHOLOXIN (sodium dextrothyroxine) to euthyroid patients with one or more of the following conditions is contraindicated:

1. Known organic heart disease, including angina pectoris; history of myocardial infarction; cardiac arrhythmia or tachycardia, either active or in patients with demonstrated propensity for arrhythmias; rheumatic heart disease: history of congestive heart failure; and decompensated or borderline compensated cardiac status.
2. Hypertensive states (other than mild, labile systolic hypertension).
3. Advanced liver or kidney disease.
4. Pregnancy.
5. Nursing mothers.
6. History of iodism.

Warnings
CHOLOXIN (sodium dextrothyroxine) may potentiate the effects of anticoagulants on prothrombin time. Reductions of anticoagulant dosage by as much as 30% have been required in some patients. Consequently, the dosage of anticoagulants should be reduced by one-third upon initiation of CHOLOXIN therapy and the dosage subsequently readjusted on the basis of prothrombin time. The prothrombin time of patients receiving anticoagulant therapy concomitantly with CHOLOXIN therapy should be observed as frequently as necessary, but at least weekly, during the first few weeks of treatment.

In the surgical patient, it is wise to consider withdrawal of the drug two weeks prior to surgery if the use of anticoagulants during surgery is contemplated.

When CHOLOXIN is used as thyroid replacement therapy in hypothyroid patients with concomitant coronary artery disease (especially those with a history of angina pectoris or myocardial infarction) or other cardiac disease, treatment should be initiated with care. Special consideration of the dosage schedule of CHOLOXIN is required. This drug may increase the oxygen requirements of the myocardium, especially at high dosage levels. Treated subjects with coronary artery disease must be seen at frequent intervals. If aggravation of angina or increased myocardial ischemia, cardiac failure, or clinically significant arrhythmia develops during the treatment of hypothyroid patients, the dosage should be reduced or the drug discontinued.

Special consideration must be given to the dosage of other thyroid medications used concomitantly with CHOLOXIN. As with all thyroactive drugs, hypothyroid patients are more sensitive to a given dose of CHOLOXIN than euthyroid patients.

Epinephrine injection in patients with coronary artery disease may precipitate an episode of coronary insufficiency. This condition may be enhanced in patients receiving thyroid analogues. These phenomena should be kept in mind when catecholamine injections are required in sodium dextrothyroxine-treated patients with coronary artery disease.

Since the possibility of precipitating cardiac arrhythmias during surgery may be greater in patients treated with thyroid hormones, it may be wise to discontinue CHOLOXIN in euthyroid patients at least two weeks prior to an elective operation. During emergency surgery in euthyroid patients, and in surgery in hypothyroid patients in whom it may be advisable to withdraw therapy, the patients should be carefully observed.

There are reports that sodium dextrothyroxine in diabetic patients is capable of increasing blood sugar levels with a resultant increase in requirements of insulin or oral hypoglycemic agents. Special attention should be paid to parameters necessary for good control of the diabetic state in dextrothyroxine-treated subjects and to dosage requirements of insulin or other antidiabetic drugs. If sodium dextrothyroxine is later withdrawn from patients who had required an increase of insulin (or oral hypoglycemic agents) dosage during its administration, the dosage of antidiabetic drugs should be reduced and adjusted to maintain good control of the diabetic state.

When either or both impaired liver or kidney function are present, the advantages of CHOLOXIN therapy must be weighed against the possibility of deleterious results.

Usage in Women of Childbearing Age
Women of childbearing age with familial hypercholesterolemia or hyperlipemia should not be deprived of the use of this drug; it can be given to those patients exercising strict birth control procedures. Since pregnancy may occur despite the use of birth control procedures, administration of CHOLOXIN (sodium dextrothyroxine) to women of this age group should be undertaken only after weighing the possible risk to the fetus against the possible benefits to the mother. Teratogenic studies in two animal species have resulted in no abnormalities in the offspring.

Precautions
It is expected that patients on dextrothyroxine therapy will show greatly increased serum protein-bound-iodine levels. These increased serum PBI values are evidence of absorption and transport of the drug, and should NOT be interpreted as evidence of hypermetabolism; similarly, they may not be used for titrating the effective dose of CHOLOXIN (sodium dextrothyroxine). PBI values in the range of 10 to 25 mcg% in treated patients are common.

If signs or symptoms of iodism develop during CHOLOXIN therapy, the drug should be discontinued.

A few children with familial hypercholesterolemia have been treated with CHOLOXIN for periods of one year or longer with no adverse effects on growth. However, it is recommended that the drug be continued in patients in this age group only if a significant serum cholesterol-lowering effect is observed.

Adverse Reactions
The side effects attributed to dextrothyroxine therapy are, for the most part, due to increased metabolism, and may be minimized by following the recommended dosage schedule. Adverse effects are least commonly seen in euthyroid patients with no signs or symptoms of organic heart disease; the incidence of adverse effects is increased in hypothyroid patients, and is highest in those patients with organic heart disease superimposed on the hypothyroid state.

In the absence of known organic heart disease, some cardiac changes may be precipitated during sodium dextrothyroxine therapy. In addition to angina pectoris, arrhythmia consisting of extrasystoles, ectopic beats, or supraventricular tachycardia, ECG evidence of ischemic myocardial changes and increase in heart size have been observed. Myocardial infarctions, both fatal and non-fatal, have occurred, but these are not unexpected in untreated patients in the age groups studied. It is not known whether any of these infarcts were drug related.

Changes in clinical status that may be related to the metabolic action of the drug include the development of insomnia, nervousness, palpitations, tremors, loss of weight, lid lag, sweating, flushing, hyperthermia, hair loss, diuresis, and menstrual irregularities. Gastrointestinal complaints during therapy have included dyspepsia, nausea and vomiting, constipation, diarrhea, and decrease in appetite.

Other side effects reported to be associated with CHOLOXIN (sodium dextrothyroxine) therapy include the development of headache, changes in libido (increase or decrease), hoarseness, tinnitus, dizziness, peripheral edema, malaise, tiredness, visual disturbances, psychic changes, paresthesia, muscle pain, and various bizarre subjective complaints. Skin rashes, including a few which appeared to be due to iodism, and itching have been attributed to dextrothyroxine by some investigators. Gallstones have been discovered in occasional dextrothyroxine-treated patients and cholestatic jaundice has occurred in one patient, although its relationship to CHOLOXIN therapy was not established.

In several instances, the previously existing conditions of the patient appeared to continue or progress during the administration of CHOLOXIN; a worsening of peripheral vascular disease, sensorium, exophthalmos, and retinopathy have been reported.

CHOLOXIN potentiates the effects of anticoagulants, such as warfarin or Dicumarol, on prothrombin time, thus indicating a decrease in the dosage requirements of the anticoagulants. On the other hand, dosage requirements of antidiabetic drugs have been reported to be increased during dextrothyroxine therapy (see WARNINGS section).

Dosage and Administration
For **adult** euthyroid hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN (sodium dextrothyroxine) is 4 to 8 mg per day. The initial daily dose should be 1 to 2 mg to be increased in 1 to 2 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, if that dosage level is indicated to effect the desired lowering of serum cholesterol.

When used as partial or complete substitution therapy for levothyroxine in hypothyroid patients with cardiac disease who cannot tolerate other types of thyroid medication, the initial daily dose should be 1 mg to be increased in 1 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, preferably the lower dosage. The maximum in patients receiving digitalis therapy is 4 mg.

For **pediatric** hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN is approximately 0.1 mg per kilogram. The initial daily dosage should be approximately 0.05 mg per kilogram to be increased in up to 0.05 mg per kilogram increments at monthly intervals. The recommended maximal dose is 4 mg daily, if that dosage is indicated to effect the desired lowering of serum cholesterol.

If new signs or symptoms of cardiac disease develop during the treatment period, the drug should be withdrawn.

How Supplied
CHOLOXIN (sodium dextrothyroxine) is supplied in prescription packages of scored 1, 2, 4, and 6 mg tablets.

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As physicians you know that while many pharmaceutical products prevent or alleviate many ills, some actually are life-saving immediately after administration; e.g. Adrenalin and Benadryl which can dramatically reverse fatal anaphylactic shock as the result of an insect sting; or lidocaine hydrochloride, which when administered intravenously can stop fatal ventricular fibrillation. I am sure you can name many more.

I was a fighter pilot and sometime test pilot in the navy prior to my transfer to the medical department. I think that experience taught me something that was useful later when I became involved in assuring the quality of drug products to be used on my fellow military personnel. No matter how much planning went into the design of an airplane and how much care was taken during the assembly of a plane, the final test came when the pilot took it off for the first time. If it did not perform properly, the pilot could die. The ejection seat and parachute had to perform properly the first time needed or you lost a life. A similar analogy can be made with an injection of adrenalin or lidocaine. They must perform as expected the first time or we lose a patient. I am always reminded of the statement attributed to Col. John Glenn when asked what his final thoughts were just prior to his blast off into earth orbit for the first time: They were "and to think that this space craft was put together by the lowest bidder." I believe I can assure you, however, that many "low bidders" were rejected as supplier for many parts in the first space craft, otherwise, Col. Glenn would not have been with us today. If the truth were known, I am certain there are millions living today because some dedicated people such as Max Feinberg of the defense personnel support center are there to make certain that the drug products available will perform as expected.

Perhaps the following slogans adopted by the dedicated personnel of the military medical procurement agency over the years provide a clue to success of their operation.

1. Quality will never be sacrificed for price or expediency.
2. If you would hesitate to administer this product to yourself or a member of your family, then the item must be rejected.
3. The *bitterness* of poor quality persists long after the *sweetness* of low price is forgotten.

I would like to quote another statement similar to some which many firms have used recently but one which the military medical procurement agency recognized many years ago. "Quality cannot be *tested* into a drug product; it must be *built* into the product at every stage of development and production."

No more than does society, does medicine have a philosophical position which enables us to function clearly, comfortably and effectively in the interest of mankind in this new world.

At some time in the past, several hundred years ago, it was decided that medicine was biology applied to human illness, hence, development of the biological and physical sciences basic to medicine. During the last 10 to 15 years, it dawned upon us that human behavior is basic to understanding of illness and its treatment, and while imperfectly applied as yet, the behavioral sciences are as fundamental to medicine as the biological and physical sciences. The term "human biology" now includes behavior as one of its essential components.

The next step must be the incorporation of the humanities, with perhaps even recognition that medicine established as it is by society to relieve human suffering is in fact an ultimate humanity. There is in this country an interdisciplinary group consisting of physicians, philosophers and other interested people concerned with medicine and human values. At its most recent meeting, a philosophical position such as that which I have just implied is lacking for medicine was described as an urgent necessity. The movement is underway.

In this institution, as in others, a very early and tenuous relationship has been established with a department in the College of Arts and Letters, with one or two part-time joint appointments having existed, and with one of our medical students working on a PhD in philosophy, as it relates to health. A recent publication by him in a national journal suggests the need for a whole new kind of contract between doctors and patients, with formal emphasis on the patient's role in the system. Hopefully, this relationship will expand, so that mutual benefits derived from medicine collaborating with the sciences can be expanded to the humanities as well.

This, then, would be getting it all together for medicine in the university, and hopefully for society in general. If, in fact, as I believe to be the case, a large university such as this is in some respects a microcosm and a workshop for solving the problems of the larger society, it would appear to be conceivable that the process of interaction between the health professional schools on this campus and other segments of the academic community could produce some principles and hypotheses generally testable by seminars, courses, research projects or administrative arrangements. Thence, one can consider application to community, state, and the world at large.

Monthly Surveillance Report

Cases of Certain Diseases
Reported to the Michigan Department of Public Health
For the four-week period ending Nov. 30, 1973

MICHIGAN DEPARTMENT OF PUBLIC HEALTH

	1973 This 4-Week Period	1972 Same 4-Week Period	1973 Total To Above Date	1972 Total Same Date	Total Cases for 1972
Rubella	54	54	1,942	1,389	1,460
Cong. Rubella Syndrome	0	0	1	1	1
Measles	63	181	4,488	2,242	2,353
Whooping Cough	5	8	72	109	116
Diphtheria	0	0	0	1	1
Mumps	406	325	4,575	3,258	3,729
Scarlet Fever & Strep Sore Throat	2,691	1,380	21,124	11,322	13,304
Tetanus	0	1	1	2	2
Poliomyelitis (paralytic)	0	0	0	0	1
Hepatitis	304	321	3,571	3,986	4,322
Salmonellosis (other than S. typhi)	63	51	713	746	781
Typhoid Fever (S. typhi)	1	0	13	7	7
Shigellosis	54	32	569	538	574
Aseptic Meningitis	25	31	414	246	266
Encephalitis	9	18	157	102	108
Meningococcic Meningitis	4	6	48	54	55
H. Influenza Meningitis	6	7	83	73	81
Tuberculosis	89	101	1,273	1,499	1,609
Syphilis	384	358	4,017	4,452	4,815
Gonorrhea	2,305	2,136	28,417	22,674	24,728

Information can be supplied by the local health department on the local incidence of disease.

Maurice Reizen, MD, Director
Michigan Department of Public Health

*corrected totals

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Kenneth B. Welsh, MD, 100 Oak St., Wyandotte 49192
Alan N. Wilson, MD, Detroit General Hosp., Detroit 48226
Bie-Chin B. Wu, MD, 3825 Brush, Detroit 48201
Ho-Ming Yian, MD, 2909 E. Grand River, Lansing 48912
Jinwoo Yoo, MD, 12632 Dexter, Detroit 48238

AMA Trustees Name 3 From State to Serve on Official Bodies

Three Michigan physicians have received appointments to American Medical Association committees and councils for 1974. The appointments were made by the AMA Board of Trustees for one-year terms.

Maurice H. Seevers, MD, of Ann Arbor, was appointed to the Committee on Drug Dependence, a new committee created along with the Committee on Alcoholism to replace the former Committee on Alcoholism and Drug Dependence.

Robert E. Rice, MD, of Greenville, was reappointed to the Council on Rural Health and Otto K. Engelke, MD, of Ann Arbor, was reappointed to the Council on Environmental, Occupational and Public Health. Also announced was the retirement of William W. Jack, MD, of Grand Rapids, from the Committee on Maternal and Child Care.

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References: 1. Modell, W., ed.: Drugs of Choice 1970-1971, St. Louis, The C. V. Mosby Company, 1970, p. 196. **2.** Goodman, L. S., and Gilman, A., ed.: The Pharmacologic Basis of Therapeutics, ed. 4, New York, The Macmillan Company, 1970, p. 327. **3.** Maslansky, L.: Paper delivered at Fourth International Congress of Allergology, New York, Oct. 18, 1961 abstracted Excerpta Med. Internat. Congress Series, No. 42, p. 124.

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Briefly Noted

Mary O. Anderson, MD, of Leonidas, and Richard C. Bates, MD, of Lansing,
were among "110 handpicked medical thinkers" selected and interviewed by *Medical Economics* magazine for a recent issue forecasting what will happen on health care issues by 1978. The two Michigan doctors were quoted in a discussion of office and hospital based medical practice. "Most doctors would rather see patients on a private-office basis," said Doctor Anderson, adding "I don't think patients who have the choice will settle for seeing a doctor in a hospital, where physician and patient tend to lose each other in the shuffle." Doctor Bates agreed: "The bulk of office medical practice is triage, counseling, reassurance and health maintenance. It's a sort of game played between doctor and patient: vitamin shots, a pill for every ill, scold me so I'll know you care. This will never move successfully into hospitals because it requires continuity and intimacy—and that can't be standardized or regulated."

Duane L. Block, MD, of Dearborn,
has been named president-elect of the Michigan Health Council. Doctor Block is medical director for the Ford Motor Co. J.K. Altland, MD, of Lansing, was elected MHC medical advisor. John C. McCabe, of Detroit, president of Michigan Medical Service, is the new Michigan Health Council president, succeeding Robert E. Rice, MD, of Greenville. Doctor Rice was reelected to the MHC board and C. Allen Payne, MD, of Grand Rapids, was named a trustee.

Harold E. Bowman, MD, of Grand Rapids,
has been reelected to the board of directors of the American Cancer Society. Doctor Bowman, who is director of pathology at St. Mary's Hospital, Grand Rapids, is medical chairman of the Kent County Unit of the American Cancer Society and chairman of the Kent County Medical Society's cancer committee.

Darrell A. Campbell, MD, of Ann Arbor,
has been elected president of the Western Surgical Association, which has a membership limited to 450 surgeons in a geographic area extending from Cleveland to the West Coast. Doctor Campbell is a general surgeon at St. Joseph Mercy Hospital in Ann Arbor, where he has been a staff member for 24 years. He is a former chief of staff and since 1968 has been clinical professor of surgery at the University of Michigan Hospitals.

John M. Dorsey, MD, of Highland Park,
has been named the outstanding citizen of Highland Park for his 20 years of service on the community's board of education. He received a citation at a recent meeting of the Highland Park City Council. Doctor Dorsey is president emeritus of psychiatry at Wayne State University School of Medicine.

Edmund J. Dudzinski, MD, of Mount Clemens,
has been appointed to the MSMS Judicial Commission to replace Robert J. Mason, MD, of Birmingham, who resigned at the end of 1973. Doctor Dudzinski, who will serve until the end of 1974, was appointed by Brooker L. Masters, MD, MSMS president.

Vlado A. Getting, MD, of Ann Arbor,
has been appointed chairman of the department of allied health services at Florida Technological University in Orlando. Doctor Getting leaves the University of Michigan where he has been a faculty member since 1953. He has been chairman of community health services and professor of public health administration at the U-M School of Public Health. Doctor Getting served as acting director of the Washtenaw County Health Department from January until August of last year.

Orlen J. Johnson, MD, of Bay City,
has been appointed to the board of the Michigan Association of the Professions.

Edward J. Lynn, MD, of Lansing,
director of the St. Lawrence Community Mental Health Center, is the author of two booklets, on "Suicide" and "Psychosis," published recently by the National Drug Abuse Training Center, Washington, D.C.

Walter D. Meester, MD, of Grand Rapids,
has been appointed to the new Michigan Advisory Commission on Substance Abuse by

Gov. Milliken. Doctor Meester is director of medical research at Blodgett Memorial Hospital in Grand Rapids and directs the Michigan Drug Detection Center in Grand Rapids.

Russell J. Paalman, MD, of Grand Rapids,
has been elected president of the Central Association of Obstetrics and Gynecology. The association covers 28 states and has a membership limited to 500 OB-Gyn specialists.

Jerry C. Rosenberg, MD, of Huntington Woods,
professor of surgery at the Wayne State University School of Medicine, has been named director of surgical education at Hutzel Hospital. A specialist in kidney transplants, Doctor Rosenberg also directs the Robert S. Marx Surgical Research Laboratories at the WSU Medical School.

Donato F. Sarapo, MD, of Adrian,
has been reappointed by Gov. Milliken to the State Athletic Board of Control. Doctor Sarapo, who was first appointed to the board in 1969, was reappointed to a new term running until 1977. Doctor Sarapo is a member of the MSMS Council.

Kenneth G. Schooff, MD, of Detroit,
is director of Michigan's first federally supported program to detoxify and treat addicts who primarily use drugs other than heroin or alcohol, established recently at Harper Hospital. The new program, established through a $387,000 grant from the National Institute of Mental Health, will serve addicts who use sedative-hypnotic drugs, amphetamines, hallucinogens or a combination of such drugs, Doctor Schooff said. Patients aged 14 and older from throughout Michigan will be accepted.

Joseph C. Steffey, MD, of Traverse City,
has been named to head a fund drive to raise $500,000 for an endowed chair in biological sciences at Albion College, honoring A. Merton Chickering, PhD. Doctor Chickering was professor and chairman of Albion's biology department for 39 years and helped guide many students into medicine and other scientific professions. College records list 525 currently practicing physicians among Albion graduates. Doctor Steffey was graduated from Albion in 1944.

Charles Zimont, MD, of Constantine,
has been elected a vice president of Interstate Postgraduate Medical Education. Donald DeWitt, MD, of Holland, recently completed a year as vice president.

Two Allegan County Physicians
were honored recently for their contributions to family medical care. The two, James E. Mahan, MD, of Allegan, and E. B. Johnson, MD, of Pullman, were honored by 1,000 Allegan area residents who turned out for a reception given by the Allegan Lions Club. The two family doctors have practiced in the Allegan area for a combined total of more than 75 years.

Michigan State University, East Lansing,
has awarded contracts totaling 15½ million dollars for construction of a new clinical sciences building to provide facilities for the College of Human Medicine and the College of Osteopathic Medicine.

The Forensic Science Foundation
has asked Michigan physicians for help in a research project to define and evaluate the services performed by the forensic science profession in the criminal justice process. The foundation would like contact from physicians who have given reports or testimony as expert witnesses in criminal court or elsewhere in the criminal justice process since 1972. The foundation has asked that doctors who have had this kind of experience send a card or note with name, address and area of expertise to: Forensic Sciences Foundation, 11400 Rockville Pike, Rockville, Md. 20852. The foundation then will send a questionnaire to be completed as a contribution to the study. The research is federally sponsored and all information provided to the foundation will be treated as confidential.

Medical Assistants
have until Feb. 1 to apply to take a specialty certification examination in pediatrics to be offered for the first time by the American Association of Medical Assistants next June 28 in 70 centers around the country. The American Academy of Pediatrics is cooperating. Feb. 1 also is the deadline for applications for the administrative and clinical examinations for medical assistants given by the AAMA. Applicants may obtain information packets from the American Association of Medical Assistants, 1 E. Wacker Dr., Chicago, Ill. 60601.

Blue Cross and Emma L. Bixby Hospital
in Adrian have negotiated a "prospective reimbursement" agreement under which the hospital will provide services to Blue Cross members for an annual negotiated amount. Bixby is the first of 12 Michigan hospitals which volunteered to join in a three-year pilot program to determine if lower costs are obtainable through the new payment system.

Medico-Legal

The AMA's Citation *newsletter, prepared by the AMA Law Department, lists the following cases involving health personnel in Michigan. Persons interested in obtaining more information on individual cases may write MSMS headquarters.*

"Landlord liable for attack by mental clinic patient"
Michigan Court of Appeals, April 2, 1973
from *The Citation,* Vol. 27, No. 7

"Statutory control over body donated to medical school"
Michigan Court of Appeals, Jan. 17, 1973
from *The Citation,* Vol. 27, No. 7

"Death from serum hepatitis held unavoidable risk"
Michigan Court of Appeals, Aug. 29, 1972
from *The Citation,* Vol. 27, No. 8

"Public hospital held not immune from suit"
Federal District Court, Michigan, March 7, 1973
from *The Citation,* Vol. 27, No. 10

In Memoriam

Thomas L. Banks, MD, Southfield

Thomas L. Banks, MD, 39, of Southfield, died Dec. 23. He was a specialist in ophthalmology. A native of Detroit, Doctor Banks was graduated from the Wayne State University School of Medicine.

He was a member of the Detroit Ophthalmological Society, the American Association of Ophthalmologists and the Detroit Surgical Society.

Clarence L. Becklein, MD, Detroit

Clarence L. Becklein, MD, of Detroit, a member of the staff of Evangelical Deaconess Hospital for 45 years, died Dec. 1 at the age of 73. Doctor Becklein was graduated from the Detroit College of Medicine, now Wayne State University School of Medicine, in 1928. A family physician, he had served also on the staff of Receiving Hospital and as Detroit city physician.

(Continued on Page 56)

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Brief Summary

Indications—Placidyl (ethchlorvynol) is indicated as short-term hypnotic therapy in the management of insomnia.

Contraindications—Drug hypersensitivity and porphyria.

Warnings—Not recommended during the first and second trimester of pregnancy. Caution patients of possible combined exaggerated effects with alcohol, barbiturates, tranquilizers or other CNS depressants. Exaggerated effects might result in blurring of vision, paralysis of accommodation and profound hypnosis. Caution patients concerning driving a motor vehicle, operating machinery, or other hazardous operations requiring alertness after taking the drug. ADMINISTER WITH CAUTION TO PATIENTS WITH SUICIDAL TENDENCIES AND DO NOT PRESCRIBE LARGE QUANTITIES OF THE DRUG. Adjustment of the dosage of oral anticoagulants might be necessary when beginning ethchlorvynol therapy, during therapy, or after stopping therapy. This drug is not recommended for use in children. PLACIDYL HAS THE POTENTIAL FOR THE DEVELOPMENT OF PSYCHOLOGICAL AND PHYSICAL DEPENDENCE. INSTANCES OF SEVERE WITHDRAWAL SYMPTOMS, INCLUDING CONVULSIONS AND DELIRIUM CLINICALLY SIMILAR TO THOSE SEEN WITH BARBITURATES, HAVE BEEN REPORTED IN PATIENTS TAKING REGULAR DOSES AS LOW AS 1000 MG. PER DAY OVER A PERIOD OF TIME WHEN THE DRUG WAS SUDDENLY DISCONTINUED. PROLONGED ADMINISTRATION OF THE DRUG IS NOT RECOMMENDED. Addiction-prone patients or those who are likely to increase dosages of the drug on their own initiative should be observed for evidence of signs or symptoms which may indicate possible early withdrawal or abstinence symptoms. Signs and symptoms associated with withdrawal and abstinence include unusual anxiety, tremor, ataxia, slurring of speech, memory loss, perceptual distortions, irritability, agitation and delirium. Other less well defined signs and symptoms, not necessarily due to withdrawal and abstinence, may include anorexia, nausea or vomiting, weakness, dizziness, sweating, muscle twitching and weight loss. Abrupt discontinuance of Placidyl following prolonged overdosage may result in convulsions and delirium.

Precautions—Toxic amblyopia has been reported with long-term continuous use of ethchlorvynol. Permanent visual defects have been observed, although amblyopia has improved after discontinuation of the drug. Drug dosage should be limited for elderly and debilitated patients to the smallest effective amount. If pain is present, this drug should only be given if insomnia persists after pain is controlled with analgesics. Caution is advised in prescribing the drug for patients who are being treated with either MAO inhibitors or antidepressants. Transient delirium has been reported with the combination of Placidyl and amitryptyline. Drug dosage should be reduced if prescribed for patients receiving MAO inhibitors or antidepressants. Caution should be exercised in patients with impaired hepatic or renal function. Patients who respond unpredictably to barbiturates or alcohol, or who exhibit excitement and release of inhibition in association with such agents, may also react in this way to Placidyl. Rarely, patients may exhibit symptoms suggestive of an unusual susceptibility to the drug; such as prolonged hypnosis, profound muscular weakness, excitement, hysteria, or syncope without marked hypotension. Transient giddiness or ataxia may occur.

Adverse Reactions—Hypotension, nausea or vomiting, gastric upset, aftertaste, blurring of vision, dizziness, facial numbness, and allergic reaction typified by urticaria have been reported following Placidyl administration. Mild "hangover" and symptoms of mild excitation have occurred in some patients. There have been rare reports of cholestatic jaundice occurring in patients taking ethchlorvynol. A few cases of thrombocytopenia have been reported in patients receiving ethchlorvynol. 306433

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Dirk C. Bloemendaal, MD
Zeeland

Dirk C. Bloemendaal, MD, 75, of Zeeland, a physician in the Ottawa County area for 40 years and former mayor of Zeeland, died Dec. 1. Doctor Bloemendaal was a native of Clear Lake, S.D., but received his early education in the Netherlands. He was graduated from Jefferson Medical College in Philadelphia in 1923 and came to Michigan six years later to become chief resident at Butterworth Hospital in Grand Rapids.

Doctor Bloemendaal served as mayor of Zeeland in 1952 and 1953 and from 1957 to 1963. He was a past president of the Ottawa County Medical Society and a veteran of World War I and II.

Robert H. Criswell, MD
Bay City

Robert H. Criswell, MD, a Bay City ophthalmologist and otolaryngologist for 50 years, died Dec. 9 at the age of 80. Doctor Criswell was graduated from the University of Michigan Medical School in 1915. He was a past president of the Bay County Medical Society and a former chief of staff at Bay City's Mercy Hospital. He was honored by MSMS for completion of 50 years of medical practice in 1965.

Robert J. Hornbeck, MD
Livonia

Robert J. Hornbeck, MD, of Livonia, a specialist in radiology, died Sept. 2 at the age of 56. Doctor Hornbeck was graduated from the Stritch School of Medicine of Loyola University, Chicago, and came to Michigan in 1953.

Walter J. Jaracz, Sr., MD
Grand Rapids

Walter J. Jaracz, Sr., MD, 79, a Grand Rapids physician for more than 50 years, died Dec. 27. Doctor Jaracz was graduated from the University of Illinois College of Medicine but came to Michigan and opened his practice in Grand Rapids in 1919. He was on the staff of St. Mary's Hospital there for 54 years.

Bernard S. Kalayjian, MD
Largo, Fla.

Bernard S. Kalayjian, MD, 67, of Largo, Fla., who formerly practiced radiology in Detroit, died Dec. 2. Doctor Kalayjian was graduated from Rush Medical College in Chicago and came to Michigan in 1945. He was a member of the staff of Woman's Hospital in Detroit. He belonged to the Detroit Roentgen Ray and Radium Society and the Radiological Society of North America.

Bror Hjalmar Larsson, MD
Detroit

Bror Hjalmar Larsson, MD, a Detroit physician and surgeon since 1919, died Dec. 19 at the age of 92. Doctor Larsson received his early education in his native Sweden and was graduated from the Detroit College of Medicine in 1914. He was a long time member of the staff of Harper Hospital and during World War I served as a lieutenant in the Harper Hospital unit in France and Italy.

Doctor Larsson was honored by MSMS in 1964 for completion of 50 years of medical practice. He was a fellow of the American College of Surgeons and a past president of the Alumni Society of the Detroit College of Medicine.

William M. LeFevre, MD
Muskegon

William M. LeFevre, MD, a Muskegon physician for 50 years died Dec. 5 at the age of 77. A graduate of the University of Michigan Medical School, Doctor LeFevre was a specialist in internal medicine. He served as physician for the E.I. Du Pont de Nemours Montague plant after giving up his private practice in 1958.

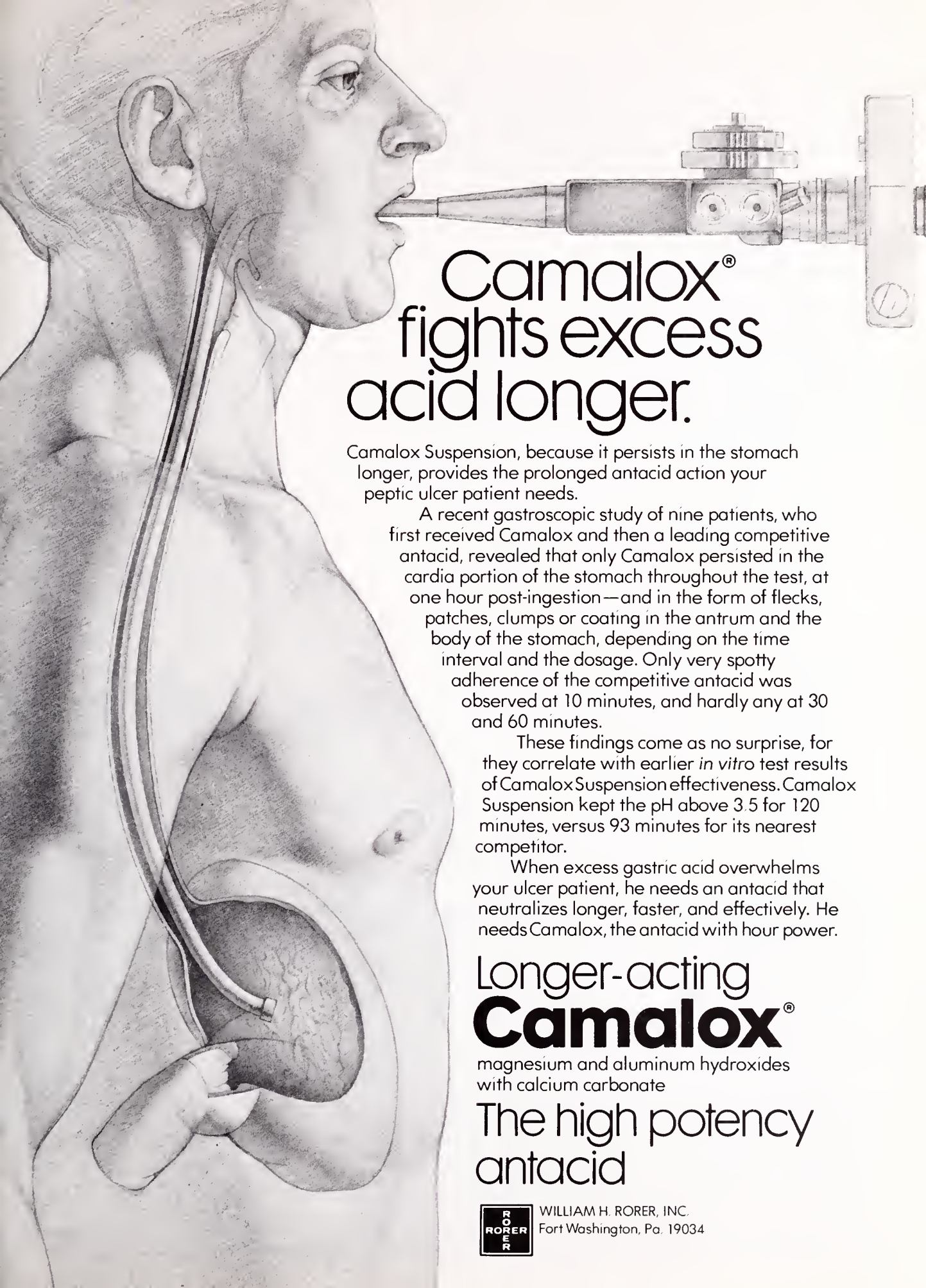
Doctor LeFevre served ten years as MSMS councilor for District 11 and received the society's 50 year award at the 1973 Annual Session last October in Detroit. He also was a past president of the Muskegon County Medical Society and the Michigan Diabetes Association and was a founder and first president of the Michigan Association of the Professions. In 1961 he received the Michigan State Pharmaceutical Association's Distinguished Service Award for his contributions to MAP. In 1965, Doctor LeFevre received a citation signed by President Lyndon B. Johnson for 25 years of service as a selective service physician. He was a former chief of staff at Mercy Hospital in Muskegon and also has served as medical section chief at both Mercy and Hackley Hospitals.

Bernard E. Nolan, MD
Dearborn

Bernard E. Nolan, MD, 58, of Dearborn, died Dec. 6. A specialist in obstetrics and gynecology, Doctor Nolan was a graduate of the University of Arkansas School of Medicine, Little Rock.

Arthur R. Smeck, MD
East Lansing

Arthur R. Smeck, MD, of East Lansing, formerly of Detroit, died Dec. 21 at the age of 90. Doctor Smeck was a graduate of the American Medical Missionary College and practiced in Detroit from 1910 until his retirement in 1968. He served as a army major during World War I.



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Book Review

"The Complete Handbook for Medical Secretaries and Assistants"
by Robert L. Dennis, M.D. and Jean Monty Doyle, R.R.L.
Published by Little, Brown and Co.
Boston, Mass. (Price $9.50)

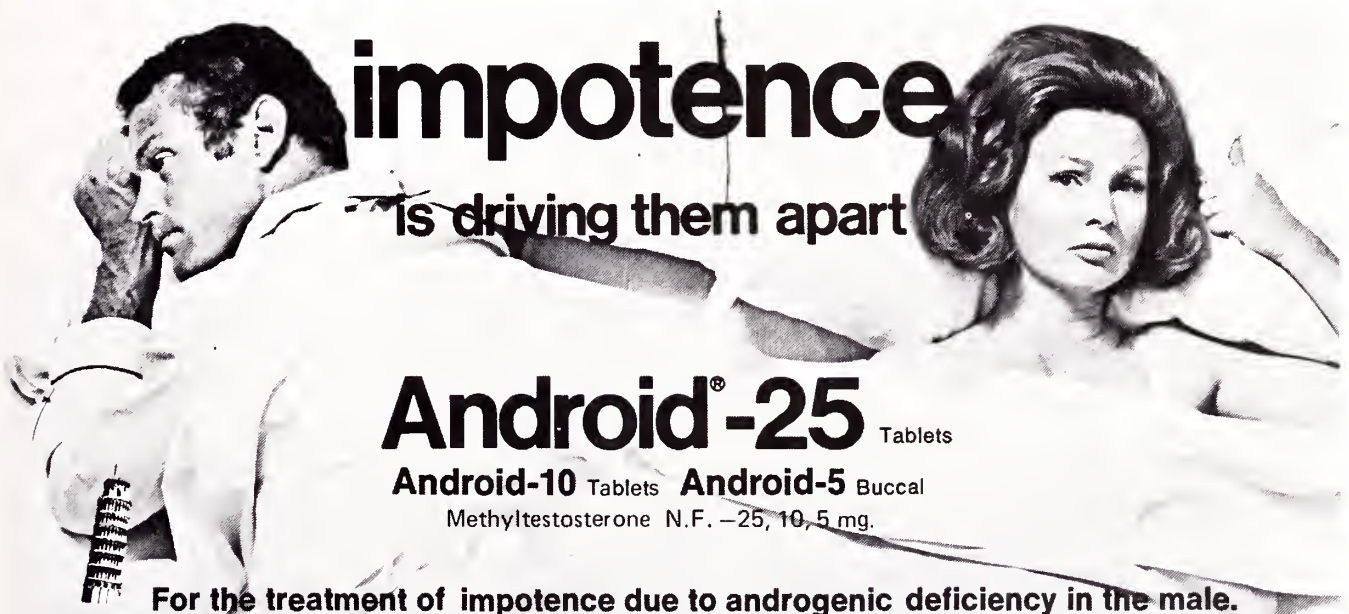
For the medical assistant or secretary new to her field, this handbook affords a single, simple source of information for all phases of the doctor's office.

The contents include chapters on duties and performance of routine secretarial tasks, bookkeeping, and a fairly comprehensive description of insurance forms.

With a "dictionary" type of reference without depth, the new medical assistant will find enlightening information on medical and anatomical terminology and vocabulary, the clinical laboratory and radiology. There are examples of the medical history and physical examination reports with helpful specifics from each medical specialty.

The detailed information on routine laboratory procedures would be very helpful and also, the excellent glossary listing.

—Reviewed by Audrie Chute, President, Association of Medical Assistants — State of Michigan.



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DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptome when these are secondery to endrogen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpuberal cryptorchidism with evidence of hypogonedism. Cholestetic hepatitis with jaundice and altered liver function tests, such as increased BSP retention and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients very widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the **male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

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Beating the Deadline

By Herbert A. Auer
Executive Editor

"The way Doctor Schneiter picked up leads when he examined the patient was just like the ideal interview we created in class," wrote Kathy Makielski, 19, in a recent issue of *U-M Alumnus* magazine. Kathy reported on her experiences with Harry Schneiter, MD, during a four-week visit with the Allegan doctor. Kathy is one of the 50 students in the U-M accelerated medical curriculum.

The possibility of a SAMA project in the Upper Peninsula much like the SAMA volunteer medical service program in Appalachia is under study by an ad hoc MSMS committee and leaders of the three Michigan SAMA chapters. Funding is available from national SAMA from a Kellogg Foundation grant. MSMS Councilor Raymond Hockstad, MD, of Escanaba, represented the UP at the first exploratory meeting.

Roy V. Cooley, MD, of Pontiac, can tell some interesting stories about the proposal to move the Detroit Tigers to Pontiac. As a member of the Pontiac City General Building Authority, he was involved in the early discussions about a new stadium. He is a former member of the Pontiac City Council.

"Michigan delivered more doses of vaccine to physicians and clinics during the fall Immunization Action Month than any other state in the Chicago region," reported Maurice S. Reizen, MD, director of the Michigan Department of Public Health. He added, "We appreciate the active participation of MSMS in the immunization effort."

Of the 160 graduates of Wayne State University School of Medicine in 1973, 35 have indicated plans to enter family practice. "That's far more than in other recent years," commented Marilyn Heins, MD, WSU associate dean of student affairs, who interviewed each graduate and tabulated many interesting figures. If you want a copy just write to the Education Liaison Committee at MSMS.

When you take that winter break, "Don't pack in too much," warned Peter A. Martin, MD, Southfield psychiatrist, in the recent *U. S. News and World Report* feature about winter vacations. Introduced as an "authority on leisure and mental health," Doctor Martin recommended that a vacation include "as much leisure as possible" rather than extensive travel.

Dr. Heins

Dr. Blair

Dr. Cooley

Dr. Martin

Vice President Ford

"Without your assistance, the American Society for Surgery of the Hand's training program for Vietnamese doctors would not have been possible," said Alfred B. Swanson, MD, of Grand Rapids, recently, when he presented a special ASSH award to Gerald R. Ford (then congressman and now vice president) at a Kent County Medical Society meeting.

"How can I best explain heart surgery to TV viewers?" T. Calvin Blair, MD, of Lansing, asked himself when invited by MSMS to appear over Channel 19 at Saginaw. Doctor Blair made the wise decision—he took along a heart surgery patient to help answer some of the 60 questions phoned in by listeners after a panel presentation in which John Way, MD, of Saginaw, and Martin Jaffe, MD, of Bay City, also took part.

This page will appear each month with news items "on the human side" gathered from correspondence, meetings, conversations and tips we hope you will send in from time to time.

When you determine that the depressive symptoms are associated with or secondary to predominant anxiety in the psychoneurotic patient, consider Valium (diazepam) in addition to reassurance and counseling, for the psychotherapeutic support it provides. As anxiety is relieved, the depressive symptoms referable to it are also often relieved or reduced.

The beneficial effect of Valium is usually pronounced and rapid. Improvement generally becomes evident within a few days, although some patients may require a longer period. Moreover, Valium (diazepam) is generally well tolerated. Side effects most commonly reported are drowsiness, ataxia and fatigue. Caution your patients against engaging in hazardous occupations or driving.

Frequently, the patient's symptoms are greatly intensified at bedtime. In such situations, Valium offers an additional advantage: adding an *h.s.* dose to the *b.i.d.* or *t.i.d.* schedule can relieve the anxiety and thus may encourage a more restful night's sleep.

symptom complex to Valium® (diazepam)

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Valium® 2-mg, 5-mg, 10-mg tablets
(diazepam)

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The cover photo is courtesy of the Kimberly Clark Corp.

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Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. In editorials, the views expressed are those of the writer and not necessarily official positions of the society.

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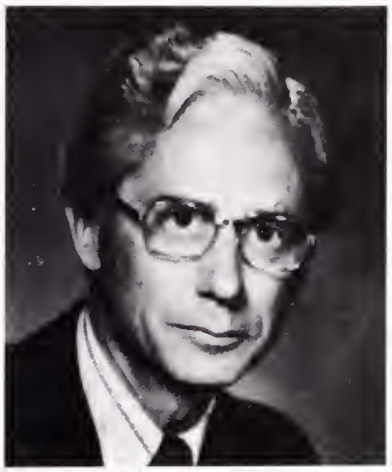
President's Page



Doctor Masters

We Need To Use Television

Please don't construe the following letter to be a forecast of doom. I do not want to reiterate the popular cliche that the free practice of medicine, as we know it, will surely disappear if the present trend of legislation and social change continues. But I further want to suggest a possible course of action to stem the seemingly inexorable advances of third party control of private practice.

There is little doubt that the decisions on how we and physicians of the future will practice will be determined in the state legislature and the U.S. Congress and within the next few years. MSMS and the AMA, plus MDPAC and AMPAC, are being heard more effectively than ever before. We are influencing the outcome of the minor skirmishes; I doubt that we have the ammunition to win the major war. We need to be realistic about our chances in the political arena. The medical profession numbers some 300,000 and we are not united as one voice, not by far. That is only 300,000 votes, as contrasted to the 70 or 80 million votes that the politicians count. In addition, we are selling something no one wants to need because no one wants to be sick and we are being amply rewarded for our services. So we are "fat cats"—but the real hooker is the numbers; we just don't have the votes when the final issues will be decided.

I also am sure that most impartial observers would agree that the continued advance of quality medical care can best be accomplished in an atmosphere of freedom, not government regulation. So what are we to do with HMO, PSRO, COLC, NHI, HEW, Medicare, Medicaid, et al? (If you think we should not worry, I urge you to read Doctor Kenneth Ray's editorial "Integrity Is a Rare Commodity" on Page 85. It is reprinted from the *Detroit Medical News.)*

If we are correct, and if we truly stand for the best medical care for all patients, then we need to secure the support of that amorphous mass of people called the public not just a 10 per cent sampling, but darn near every one of them.

Can it be done? I do not know, but I would like to try. How about TV? Could we conduct a rigorous campaign using time slots on "the tube" to honestly present the facts as they will affect every viewer? We could buy the time, "commercials" if you will, and attractively package a message in behalf of the patient. This should be an AMA campaign in cooperation with each state medical society. The signature would be "on behalf of your personal doctor, who is a member of the (appropriate state) Medical Society."

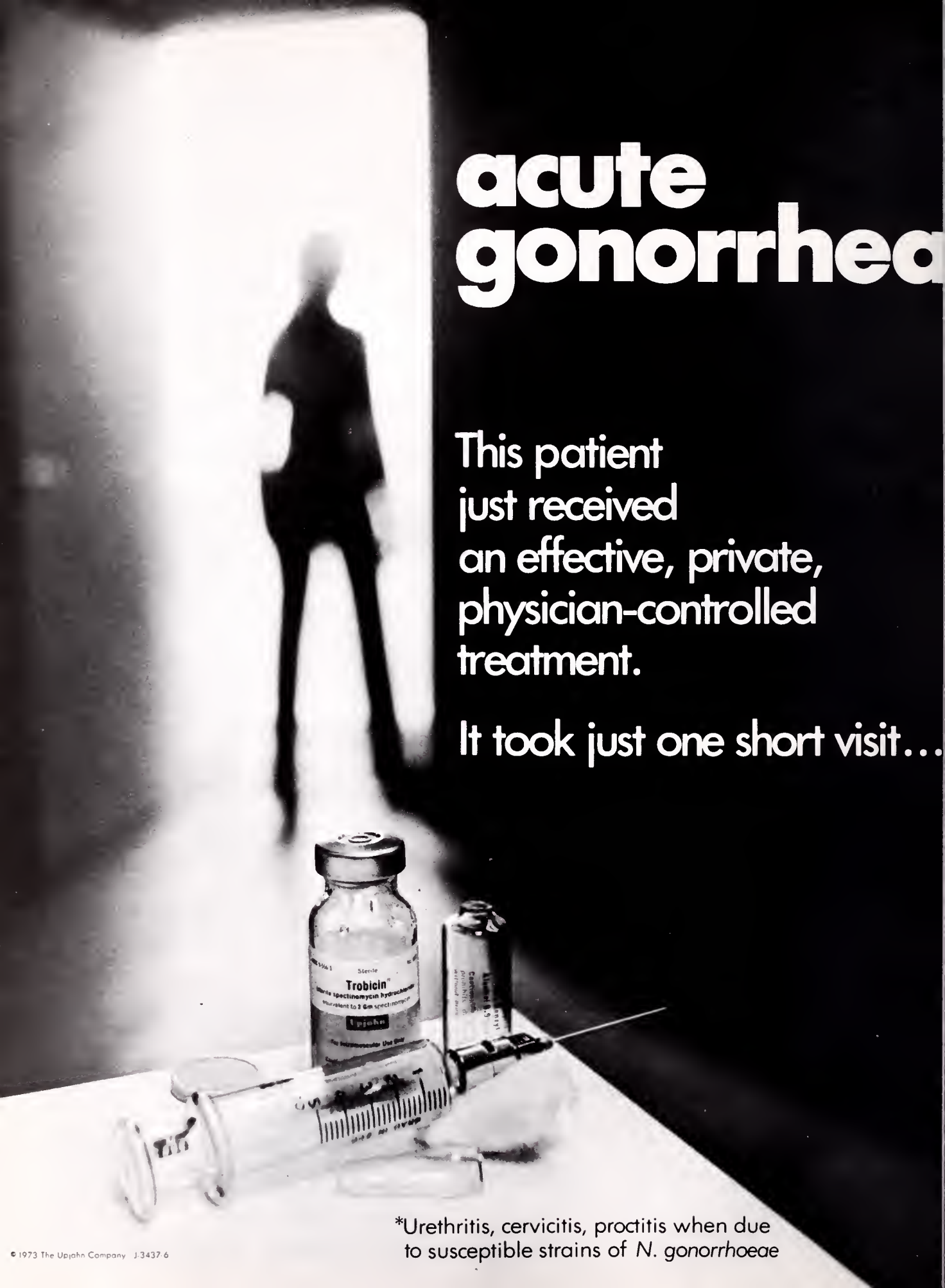
Would you be willing to contribute $100 for such a campaign? An assessment of $100 from every AMA member would produce 19 million dollars—quite a war chest. Wouldn't it be worth the gamble?

(Continued on Page 102)

acute gonorrhea

This patient
just received
an effective, private,
physician-controlled
treatment.

It took just one short visit...



*Urethritis, cervicitis, proctitis when due to susceptible strains of *N. gonorrhoeae*

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Trobicin—The advantage of injectable therapy.
Once Trobicin is injected, treatment is usually complete; there can be no problems with patients sharing, skimping, skipping or forgetting medication.

Trobicin—The aspect of privacy.
There are no prescriptions to fill, no capsules to take. Neither family, friends nor co-workers need know or suspect the patient's problem.

Trobicin—Indication and dosage.
Spectinomycin is indicated only for use in acute urethritis and proctitis in the male and acute cervicitis and/or proctitis in the female when due to susceptible strains of *N. gonorrhoeae*. The usual dosage for Trobicin in adult males is 2 grams intramuscularly†; 4 grams intramuscularly in females.

Trobicin—Not effective for syphilis.
Trobicin is not effective for any stage of syphilis. Trobicin may mask or delay the symptoms of incubating syphilis. If concurrent syphilis is suspected, follow the patient serologically for at least 3 months. Patients with syphilis should receive adequate specific anti-syphilitic therapy with an appropriate antibiotic.
Trobicin is contraindicated in patients previously found hypersensitive to it.

Intramuscular

...and Trobicin® 2 gm and 4 gm vials

sterile spectinomycin hydrochloride

Sterile Trobicin
Sterile Trobicin (spectinomycin hydrochloride) —For Intramuscular Injection:
2 gm vials containing 5 ml when reconstituted with diluent.
4 gm vials containing 10 ml when reconstituted with diluent.
An aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria gonorrhoeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between spectinomycin and penicillin.

Indications: Acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

Contraindications: Contraindicated in patients previously found hypersensitive to spectinomycin.

Warnings: Not indicated for the treatment of syphilis. Antibiotics used to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Patients should be carefully examined and monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected.
Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions should be observed with atopic individuals.
Clinical effectiveness should be monitored to detect evidence of development of resistance by *N. gonorrhoeae*.

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single- and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25° C and use within 24 hours after reconstitution with diluent.

Male—Inject 5 ml intramuscularly for a 2 gram dose. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.
Female—Inject 10 ml intramuscularly for a 4 gram dose.

How supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9%* w/v. Reconstitution yields 5 and 10 ml respectively with a concentration of 400 mg spectinomycin per ml (as the hydrochloride). For intramuscular use only.
Susceptibility Powder—for testing *in vitro* susceptibility of *N. gonorrhoeae*.
Caution: Federal law prohibits dispensing without prescription.
For additional product information see your Upjohn representative or consult the package insert.

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The Upjohn Company, Kalamazoo, Michigan 49001

† For patients with gonorrheal proctitis and for patients in geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams is preferred.

Letters

Physician Aid Needed in New Assistance Program

Members, Michigan State
Medical Society

Gentlemen:

As chief medical consultant for the Michigan Disability Determination Program, I would like to take this opportunity to express the appreciation of our medical staff to all physicians and allied medical personnel who have assisted us during the past year in furnishing medical reports for patients applying for Social Security Disability benefits. The timely receipt of these reports has been of vital importance in assuring prompt and proper evaluation of disability claims. More than 73,000 disabled workers and their dependents in this state are now receiving Social Security benefits. In 1973, a total of more than 170 million dollars helped replace the income lost due to disability.

In this agency, which makes disability determinations on behalf of the Social Security Administration for Michigan residents, the medical evidence in each case is reviewed by a physician. Since the evaluating physician never sees the applicant, he depends heavily on the data supplied by the treating sources. In the majority of our cases, the nature and extent of the claimant's impairment can be determined on the basis of evidence from the records of his treating physicians and hospital records. For this reason we are doubly grateful for the quality of the medical reports furnished us by the physicians of this state.

In January, 1974, the Social Security Administration began administering the new federal program of Supplemental Security Income (SSI), which provides financial assistance to needy people who are aged, disabled or blind. With this anticipated increase (almost double) of our state agency workload, there will be a need to expand our medical sources to obtain medical reports needed for adjudication of these new claims. Additionally, under this new program, we will be responsible for the first time for evaluating disability claims filed for children who are under the age of 18. For these reasons it is necessary for us to reach pediatricians as well as other specialists in order to effectively administer the program.

The Michigan Disability Determination Unit invites inquiries from physicians interested in serving as medical evaluators or as members of the agency panel of physicians available in their practices to perform special examinations of applicants. Physicians may send correspondence to me at Box 1200, Lansing, Mich. 48904, or telephone collect (517) 373-7830. As we enter a new year of continuing program challenge and opportunity, I want to express to you my personal thanks for your past contributions and request your continued assistance in the future.

Sincerely,

David P. Gage, MD
Chief Medical
Consultant
Michigan State Agency
Disability Determination Program

Physician Tells Distaste for PSRO

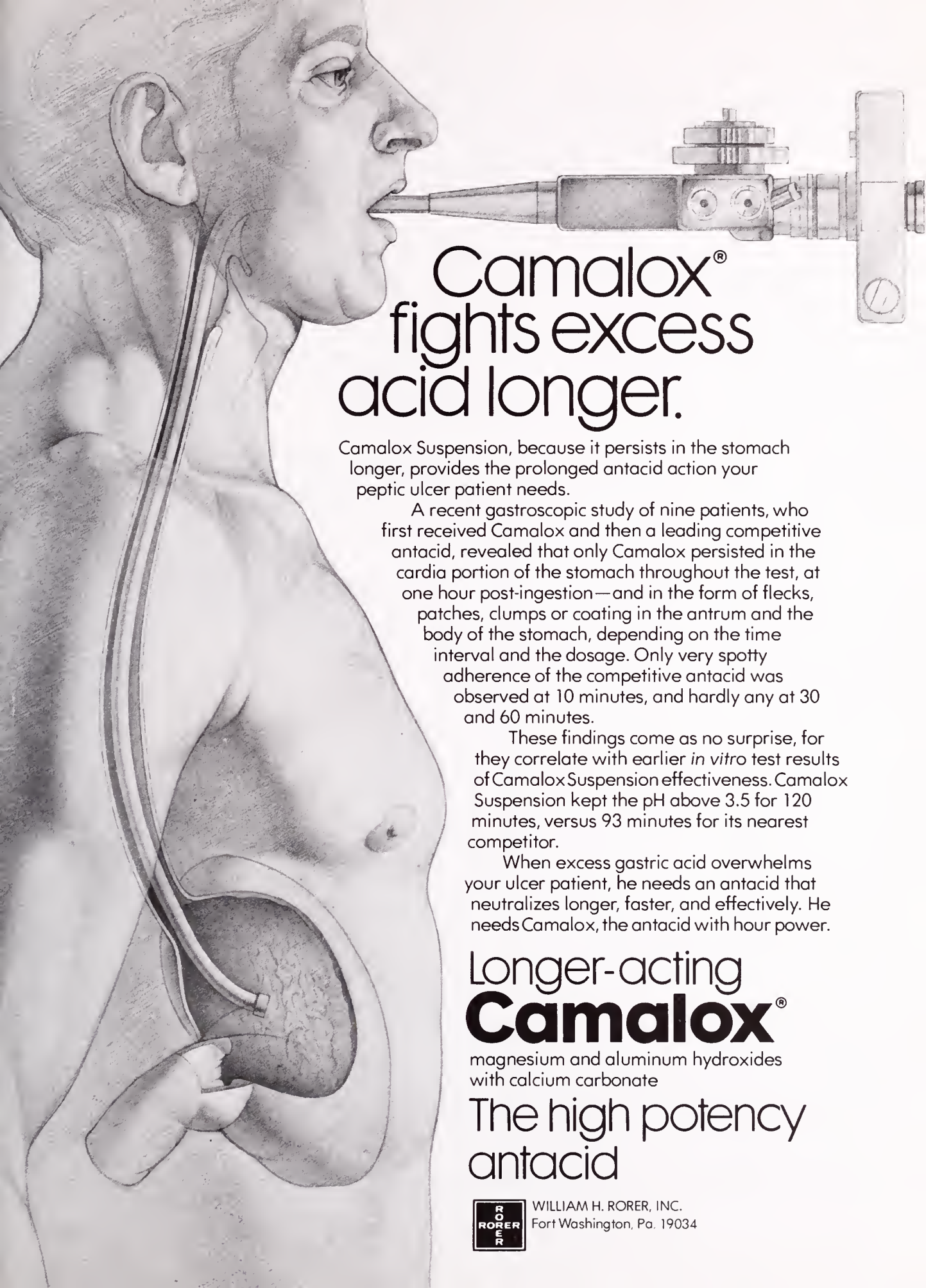
To the Editor:

Some time ago you solicited opinion of the membership regarding PSRO. I don't think I can put on this page words of sufficient expression to show my distaste, dislike and disenchantment with this PSRO. There are enough interjections of outside influences into the practice of medicine already. I would refuse to participate in any written record that criticized my peers and I would expect them to object to doing the same to me. This only gives greater ammunition to legal critics and governmental bureaucrats. It places the physician in greater jeopardy because there is a written record.

I may not approve, understand or appreciate some things that my colleagues are doing even though they may be totally correct. If I were to be critical of them and in addition put that criticism in writing I could be doing a serious disservice to not only that physician but the future of medicine. Much clinical research, innovative pioneering, etc. would suffer still further. I envision that the FDA would soon participate with about equal effectiveness as it is in curbing the pharmaceutical releases. I can't imagine who dreamed up this idea. If it was a physician, I should be most happy to sit on the Review Board and consider him one of my peers. Other than that I know of no physician of whom I could be critical at this time.

Sincerely,

J. C. Breneman, MD
Galesburg



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Camalox Suspension, because it persists in the stomach longer, provides the prolonged antacid action your peptic ulcer patient needs.

A recent gastroscopic study of nine patients, who first received Camalox and then a leading competitive antacid, revealed that only Camalox persisted in the cardia portion of the stomach throughout the test, at one hour post-ingestion—and in the form of flecks, patches, clumps or coating in the antrum and the body of the stomach, depending on the time interval and the dosage. Only very spotty adherence of the competitive antacid was observed at 10 minutes, and hardly any at 30 and 60 minutes.

These findings come as no surprise, for they correlate with earlier *in vitro* test results of Camalox Suspension effectiveness. Camalox Suspension kept the pH above 3.5 for 120 minutes, versus 93 minutes for its nearest competitor.

When excess gastric acid overwhelms your ulcer patient, he needs an antacid that neutralizes longer, faster, and effectively. He needs Camalox, the antacid with hour power.

Longer-acting **Camalox®**

magnesium and aluminum hydroxides with calcium carbonate

The high potency antacid

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MSMS Action

Council Hears Report on AMA's PSRO Action, Sets Oct. 9-10 for Next Scientific Session

Following are some of the major activities taken by the MSMS Council at its Dec. 12 meeting:

The Council heard a report from Donald N. Sweeny, Jr., MD, chairman of the MSMS delegation to the AMA, describing the MSMS efforts to have the AMA convention adopt a position to work for repeal of the PSRO law, while exerting leadership for constructive suggestions for amendments to the law, PL 92-603.

Council members discussed the possible identification of several major objectives for MSMS. This matter will be formalized at the next meeting.

The Council voted to hold the 1974 MSMS Scientific Session at the Sheraton Cadillac Hotel in Detroit, Oct. 9-10.

President Masters reported that an informal meeting had been held between leaders of MSMS and leaders of the State Bar of Michigan to discuss the initiation of an active liaison program re malpractice and other matters.

The Council discussed possible machinery for handling complaints from individual members about Blue Shield-Blue Cross policy matters and agreed to place the item on the agenda for the January meeting.

Past-President Coury reported that Michigan Blue Shield effective March 1 will require the use of the diagnostic coding system now used by the state for the Medicaid program. This matter was referred to the MSMS liaison committee with Blue Shield leadership.

Ralph R. Cooper, MD, chairman, MSMS Committee on Scientific and Educational Affairs, received approval for his committee to develop a "physician's bill of rights" to be considered at a future Council meeting.

Council members discussed the necessity for increased legislative activities and put the question of additional funds for the MSMS Department of Government Relations on the agenda for the next meeting.

The Council deferred action on a recommendation of the Legislative Policy Committee to draft a "white paper" on acupuncture until the next meeting.

The Council approved the recommendations of the Legislative Policy committee that MSMS oppose SB 802, 832 and 833 — three bills that would establish a formalized system of licensed blood banks for Michigan under the Department of Public Health, require labeling of all blood, seek to identify hepatitis carriers who contribute blood through blood banks and give patients an option of sources of blood.

The Council voted to ask the State Legislature to delay consideration on establishing a new Department of Human Services until MSMS and other interested groups can express their concerns and provide greater input into the specifics of any enabling legislation.

Support of SB 954 was voted. The bill would protect confidential health and medical information collection by the Department of Public Health. Support of SB 952 was voted in principle. This bill would establish a state revolving fund for loans to medical students with forgiveness provision if students practice in an area of medical need.

Council Chairman Leitch announced the appointment of Frank Walker, II, MD, of Detroit, as the new chairman of the MSMS Committee on Planning and Priorities to succeed Stuart Gould, MD, Ann Arbor, who resigned because he left Michigan.

MSMS President Masters appointed Edmund J. Dudzinski, MD of Mount Clemens, to fill the vacancy on the MSMS Judicial Commission created by the resignation of Robert J. Mason, MD, of Birmingham, who has retired and moved from Michigan.

The Council, after discussing MSMS relationships with the Michigan Health Council, voted to create a liaison committee with the MHC

(Continued on Page 71)

Choloxin®
(sodium dextrothyroxine)

Once-a-day dosage.

See reverse side for full prescribing information and dosage schedule.

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The Lipid-Lowering Agent with Once-A-Day Dosage

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AN IMPORTANT NOTE:
It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

CHOLOXIN® (sodium dextrothyroxine) Single-Tablet-A-Day Dosage Schedules

See prescribing information in package insert reproduced below.

	Starting Dosage	Increased by Increments of	Usual Maintenance	Maximal Recommended
Adult Hypercholesterolemic	1.0-2.0 mg.	monthly 1.0-2.0 mg.	4.0-8.0 mg.	4.0-8.0 mg.
Pediatric Hypercholesterolemic	0.05 mg./kg. body weight	monthly 0.05 mg./kg.	0.1 mg./kg. body weight	4.0 mg.
Hypothyroid Cardiac Patients	0.5-1.0 mg.	monthly 1.0 mg.	4.0 mg.	4.0 mg.

Choloxin®
(sodium dextrothyroxine)

Description
CHOLOXIN (sodium dextrothyroxine) is the sodium salt of the dextrorotatory isomer of thyroxine. It is chemically described as D-3,5,3′,5′-tetraiodothyronine sodium salt.

Actions
The predominant effect of CHOLOXIN (sodium dextrothyroxine) is the reduction of serum cholesterol levels in hyperlipidemic patients. Beta lipoprotein and triglyceride fractions may also be reduced from previously elevated levels.

Most of the available evidence indicates that CHOLOXIN stimulates the liver to increase catabolism and excretion of cholesterol and its degradation products via the biliary route into the feces. Cholesterol synthesis is not inhibited and abnormal metabolic end-products do not accumulate in the blood.

Indications
This is not an innocuous drug. Strict attention should be paid to the indications and contraindications.

CHOLOXIN (sodium dextrothyroxine) is an antilipidemic agent used as an adjunct to diet and other measures for the reduction of elevated serum cholesterol (low density lipoproteins) in euthyroid patients with no known evidence of organic heart disease.

The drug is also indicated in the treatment of hypothyroidism in patients with cardiac disease who cannot tolerate other types of thyroid medication.

Before prescribing, note the following: Results from a randomized clinical study have indicated a possible adverse effect when CHOLOXIN is administered to a patient receiving a digitalis preparation. There may be an additive effect. This additive effect may possibly stimulate the myocardium excessively in patients with significant myocardial impairment. CHOLOXIN dosage should not exceed 4 mg per day when the patient is receiving a digitalis preparation concomitantly. Careful monitoring of the total effect of both drugs is important.

It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

Contraindications
The administration of CHOLOXIN (sodium dextrothyroxine) to euthyroid patients with one or more of the following conditions is contraindicated:

1. Known organic heart disease, including angina pectoris; history of myocardial infarction; cardiac arrhythmia or tachycardia, either active or in patients with demonstrated propensity for arrhythmias; rheumatic heart disease; history of congestive heart failure; and decompensated or borderline compensated cardiac status.
2. Hypertensive states (other than mild, labile systolic hypertension).
3. Advanced liver or kidney disease.
4. Pregnancy.
5. Nursing mothers.
6. History of iodism.

Warnings
CHOLOXIN (sodium dextrothyroxine) may potentiate the effects of anticoagulants on prothrombin time. Reductions of anticoagulant dosage by as much as 30% have been required in some patients. Consequently, the dosage of anticoagulants should be reduced by one-third upon initiation of CHOLOXIN therapy and the dosage subsequently readjusted on the basis of prothrombin time. The prothrombin time of patients receiving anticoagulant therapy concomitantly with CHOLOXIN therapy should be observed as frequently as necessary, but at least weekly, during the first few weeks of treatment.

In the surgical patient, it is wise to consider withdrawal of the drug two weeks prior to surgery if the use of anticoagulants during surgery is contemplated.

When CHOLOXIN is used as thyroid replacement therapy in hypothyroid patients with concomitant coronary artery disease (especially those with a history of angina pectoris or myocardial infarction) or other cardiac disease, treatment should be initiated with care. Special consideration of the dosage schedule of CHOLOXIN is required. This drug may increase the oxygen requirements of the myocardium, especially at high dosage levels. Treated subjects with coronary artery disease must be seen at frequent intervals. If aggravation of angina or increased myocardial ischemia, cardiac failure, or clinically significant arrhythmia develops during the treatment of hypothyroid patients, the dosage should be reduced or the drug discontinued.

Special consideration must be given to the dosage of other thyroid medications used concomitantly with CHOLOXIN. As with all thyroactive drugs, hypothyroid patients are more sensitive to a given dose of CHOLOXIN than euthyroid patients.

Epinephrine injection in patients with coronary artery disease may precipitate an episode of coronary insufficiency. This condition may be enhanced in patients receiving thyroid analogues. These phenomena should be kept in mind when catecholamine injections are required in sodium dextrothyroxine-treated patients with coronary artery disease.

Since the possibility of precipitating cardiac arrhythmias during surgery may be greater in patients treated with thyroid hormones, it may be wise to discontinue CHOLOXIN in euthyroid patients at least two weeks prior to an elective operation. During emergency surgery in euthyroid patients, and in surgery in hypothyroid patients in whom it may be advisable to withdraw therapy, the patients should be carefully observed.

There are reports that sodium dextrothyroxine in diabetic patients is capable of increasing blood sugar levels with a resultant increase in requirements of insulin or oral hypoglycemic agents. Special attention should be paid to parameters necessary for good control of the diabetic state in dextrothyroxine-treated subjects and to dosage requirements of insulin or other antidiabetic drugs. If sodium dextrothyroxine is later withdrawn from patients who had required an increase of insulin (or oral hypoglycemic agents) dosage during its administration, the dosage of antidiabetic drugs should be reduced and adjusted to maintain good control of the diabetic state.

When either or both impaired liver or kidney function are present, the advantages of CHOLOXIN therapy must be weighed against the possibility of deleterious results.

Usage in Women of Childbearing Age
Women of childbearing age with familial hypercholesterolemia or hyperlipemia should not be deprived of the use of this drug; it can be given to those patients exercising strict birth control procedures. Since pregnancy may occur despite the use of birth control procedures, administration of CHOLOXIN (sodium dextrothyroxine) to women of this age group should be undertaken only after weighing the possible risk to the fetus against the possible benefits to the mother. Teratogenic studies in two animal species have resulted in no abnormalities in the offspring.

Precautions
It is expected that patients on dextrothyroxine therapy will show greatly increased serum protein-bound-iodine levels. These increased serum PBI values are evidence of absorption and transport of the drug, and should NOT be interpreted as evidence of hypermetabolism; similarly, they may not be used for titrating the effective dose of CHOLOXIN (sodium dextrothyroxine). PBI values in the range of 10 to 25 mcg% in treated patients are common.

If signs or symptoms of iodism develop during CHOLOXIN therapy, the drug should be discontinued.

A few children with familial hypercholesterolemia have been treated with CHOLOXIN for periods of one year or longer with no adverse effects on growth. However, it is recommended that the drug be continued in patients in this age group only if a significant serum cholesterol-lowering effect is observed.

Adverse Reactions
The side effects attributed to dextrothyroxine therapy are, for the most part, due to increased metabolism, and may be minimized by following the recommended dosage schedule. Adverse effects are least commonly seen in euthyroid patients with no signs or symptoms of organic heart disease; the incidence of adverse effects is increased in hypothyroid patients, and is highest in those patients with organic heart disease superimposed on the hypothyroid state.

In the absence of known organic heart disease, some cardiac changes may be precipitated during sodium dextrothyroxine therapy. In addition to angina pectoris, arrhythmia consisting of extrasystoles, ectopic beats, or supraventricular tachycardia, ECG evidence of ischemic myocardial changes and increase in heart size have been observed. Myocardial infarctions, both fatal and non-fatal, have occurred, but these are not unexpected in untreated patients in the age groups studied. It is not known whether any of these infarcts were drug related.

Changes in clinical status that may be related to the metabolic action of the drug include the development of insomnia, nervousness, palpitations, tremors, loss of weight, lid lag, sweating, flushing, hyperthermia, hair loss, diuresis, and menstrual irregularities. Gastrointestinal complaints during therapy have included dyspepsia, nausea and vomiting, constipation, diarrhea, and decrease in appetite.

Other side effects reported to be associated with CHOLOXIN (sodium dextrothyroxine) therapy include the development of headache, changes in libido (increase or decrease), hoarseness, tinnitus, dizziness, peripheral edema, malaise, tiredness, visual disturbances, psychic changes, paresthesia, muscle pain, and various bizarre subjective complaints. Skin rashes, including a few which appeared to be due to iodism, and itching have been attributed to dextrothyroxine by some investigators. Gallstones have been discovered in occasional dextrothyroxine-treated patients and cholestatic jaundice has occurred in one patient, although its relationship to CHOLOXIN therapy was not established.

In several instances, the previously existing conditions of the patient appeared to continue or progress during the administration of CHOLOXIN; a worsening of peripheral vascular disease, sensorium, exophthalmos, and retinopathy have been reported.

CHOLOXIN potentiates the effects of anticoagulants, such as warfarin or Dicumarol, on prothrombin time, thus indicating a decrease in the dosage requirements of the anticoagulants. On the other hand, dosage requirements of antidiabetic drugs have been reported to be increased during dextrothyroxine therapy (see WARNINGS section).

Dosage and Administration
For **adult** euthyroid hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN (sodium dextrothyroxine) is 4 to 8 mg per day. The initial daily dose should be 1 to 2 mg to be increased in 1 to 2 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, if that dosage level is indicated to effect the desired lowering of serum cholesterol.

When used as partial or complete substitution therapy for levothyroxine in hypothyroid patients with cardiac disease who cannot tolerate other types of thyroid medication, the initial daily dose should be 1 mg to be increased in 1 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, preferably the lower dosage. The maximum in patients receiving digitalis therapy is 4 mg.

For **pediatric** hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN is approximately 0.1 mg per kilogram. The initial daily dosage should be approximately 0.05 mg per kilogram to be increased in up to 0.05 mg per kilogram increments at monthly intervals. The recommended maximal dose is 4 mg daily, if that dosage is indicated to effect the desired lowering of serum cholesterol.

If new signs or symptoms of cardiac disease develop during the treatment period, the drug should be withdrawn.

How Supplied
CHOLOXIN (sodium dextrothyroxine) is supplied in prescription packages of scored 1, 2, 4, and 6 mg tablets.

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Michigan Stete Medical Sociaty wes well represented whan Gov. William G. Millikan signed tha state's new Medical Licensing Act Jen. 8. Behind the governor (left to right) ere Donald C. Smith, MD, director of tha Michigan Office of Health and Medicel Affeirs; C. Allan Peyne, MD, of Grand Repids, chairman of the Medicel Prectice Boerd; Bruce W. Ambrose, meneger of the MSMS Dapartmant of Governmant Raletions; Sherry Hell, speciel essistent for legislative lieison in Ambrose's dapartment; Robert M. Leitch, MD, of Battla Craak, MSMS Council chairman; Kenneth H. Johnson, MD, of Lansing, MSMS secretery, and Thomas R. Barglund, MD, of Portage, chairman of the MSMS Committee on Lagel Affeirs.

Milliken Signs New Medical Licensing Act

Long sought revisions in Michigan's 74-year-old medical practice came into being Jan. 8 when Gov. William G. Milliken signed the state's new medical licensing act into law. It was passed almost unanimously earlier by the Michigan House and Senate. MSMS supported the change.

The new act changes the name of the state Board of Registration in Medicine to Medical Practice Board and increases the size of its membership from 10 to 11. The new member will be a public representative. The new act gives the board added flexibility in supervising physicians' licenses and modifies requirements for taking and passing licensure examinations.

Recognizing changes in medical education, the new act substitutes "postgraduate education" for former reference to "internship and residency" training, making innovative programs possible.

The new act became effective immediately.

COUNCIL REPORT/Continued

"to be charged with effective active participation of MSMS at all levels relating to placement, public statements and positions, research and legislation as they relate to doctors of medicine and the practice of medicine."

The Council chairman was authorized to appoint a group of interested physicians to represent MSMS to provide medical input into the development of a plan to improve the well-being and health of the elderly, working with the state advisory commission on services to the aging.

In other action, the Council voted to re-establish its former active liaison committee with the State Board of Registration in Medicine, renamed the Medical Practice Board, seen as important now that the new Medical Practice Act has passed the state legislature.

Grand Rapids Meeting to Focus on High Risk Pregnancy

Two out-of-state speakers who will come to Michigan for the 1974 Michigan Conference on Maternal and Perinatal Health March 27 and 28 in Grand Rapids have been named by Lloyd A. Kammeraad, MD, of Grand Rapids, chairman for the conference.

Howard J. Osofsky, MD, of Temple University Hospital, Philadelphia, and Richard H. Aubry, MD, of the Medical Center Hospitals, Syracuse, N.Y., will make presentations during both Wednesday and Thursday sessions of the program, which will focus special attention on the high risk pregnancy.

Additional program details now are being completed and will be announced soon, Doctor Kammeraad said. The conference will be held in the Pantlind Hotel under the sponsorship of the MSMS Committee on Maternal and Perinatal Health.

Last year's conference attracted more than 700 physicians, nurses and students. For additional information, contact Helen Schulte at MSMS Headquarters in East Lansing.

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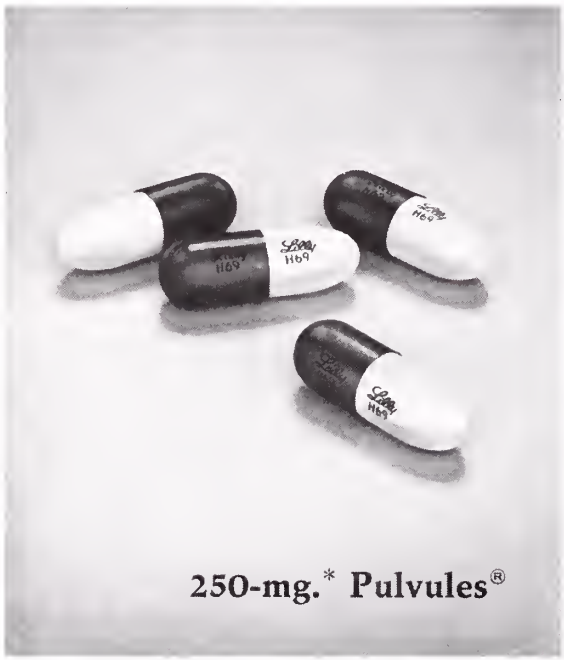

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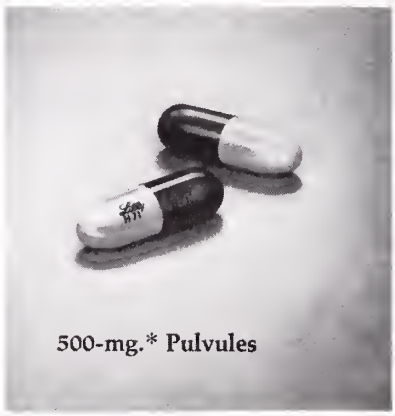

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BIOTRANSFORMATION OF ANESTHETICS: *Clinical Implications*

Part I

By Gianfranco Dal Santo, MD, Detroit

In 1963, while conducting investigations on uptake, distribution and metabolisms of anesthetics, we obtained by good fortune, a sample of ^{14}C-labeled methoxyflurane from Dow Chemical. After its administration to the experimental animal, we demonstrated[1] that a fraction of the labeling radiocarbon was present in the urine *(Figure 1).* This suggested that a traditional assumption, dating back to Haggard's 1924 studies,[2] was no longer tenable. This assumption was that inhalation anesthetics are eliminated *in toto* through the exhaled air. Later research not only confirmed this finding[3,4] but also indicated that all inhalation anesthetics, with perhaps the exception of nitrous oxide, are *biotransformed.*

Biotransformation involves the chemical modifications of a drug within a living organism. Through this process, active or inactive products (*metabolites*) are liberated. Biotransformation, however, is part of a more complex process, the *disposition* of a drug within the organism. The latter involves also distribution, redistribution,

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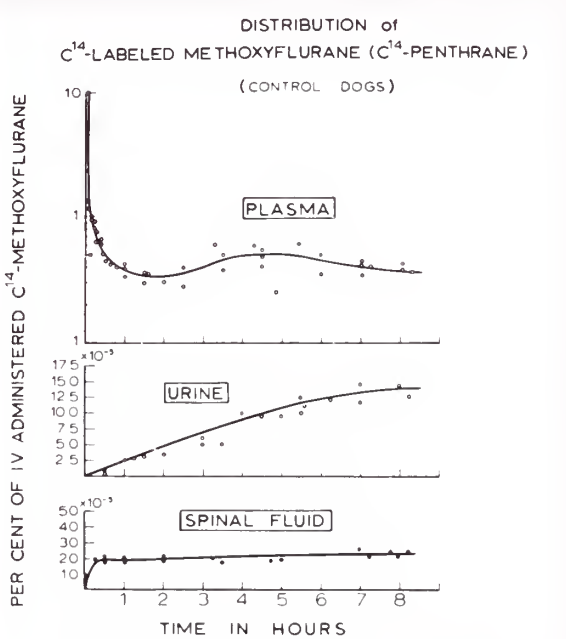

Kinetics of distribution of C-14-methoxyflurane (Penthrane) subsequent to an intravenous infusion of a trace dose. The disappearance from plasma is very rapid. Two and a half hours following administration, there is a moderate increase in the plasma concentration which may possibly be due to redistribution of the drug. The urinary elimination is active, suggesting that the traditional assumption that inhalational anesthetics are eliminated unchanged in the exhaled air is no longer tenable. The passage into the C.S.F. of the labeled methoxyflurane is rather slow. Its peak concentration is reached in about 20 minutes, then the concentration levels off.

Figure 1. Urinary elimination of radio-labeled methoxyflurane in dogs. From Dal Santo.[1] (Courtesy of F. A. Davis.)

Presented at the 18th all-day scientific meeting of the Michigan Society of Anesthesiologists, May 5, 1973, Detroit. Data reported in this article were obtained with the aid of PHS NB04123 01 02, United Health Foundation, Abbott Laboratories and Detroit General Hospital Research Corporation grants. Part II will appear in March.

The author is professor of anesthesia, Wayne State University School of Medicine, Detroit.

Scientific Articles

protein binding, storage and elimination. *(Figure 2).*

In the case of *methoxyflurane,* various biotransformation products were identified. In particular, an increase of inorganic fluoride and oxalate in the plasma and urine occurs after its administration to humans.[5-9] The most important metabolites of *halothane,* so far recognized, are bromide, chloride and trifluoracetic acid.[4] All the other inhalation anesthetics (diethyl ether, chloroform, trichloroethylene, fluroxene, forane and enflurane) are biotransformed.[4] However, because of their limited use in today's clinical anesthesia, we won't enter into details.

Intravenous anesthetics (thyobarbiturates, methohexital, neuroleptanalgesics, ketamine) are also biotransformed.[4] Actually, biotransformation plays quite an important role in the *duration* of their pharmacological effects. This is not true of the inhalation anesthetics in which biotransformation does not seem to affect significantly their length of action.

Local anesthetics, too, are biotransformed.[4] Biotransformation plays little or no role in the duration of their anesthetic effect. However, it generates metabolites which may be the cause of systemic toxic reactions.

A well-documented nephrotoxic syndrome, apparent after the administration of methoxyflurane, has been identified in certain patients.[10,11] It is characterized by polyuria, weight loss, increased serum osmolality, blood urea nitrogen, creatine and uric acid. In most cases the effects disappear in a few days or up to two to three weeks. In more serious situations the urinary parameters progressively worsen, and the abnormality can persist for longer than one-two years. In a few cases death was the ultimate result. It was associated with an increased fluoride level in plasma and urine.[5-9]

In the light of these reports, anesthesiologists started looking at methoxyflurane more critically and, at the same time, were quite concerned about the possible toxic effects of the metabolites of other agents, particularly halothane.

In regard to the renal syndrome attributed to *methoxyflurane,* one could object that immediate post-anesthetic and post-operative renal disturbances may be caused by a combination of factors of which anesthesia, if properly conducted, is a minor one. These factors may include: length and nature of the operation, inadequate fluid and electrolyte management, circulatory disturbances, autonomic nervous system and endocrine systems involvement and, finally, the simultaneous effects of other drugs (e.g., tetracycline). However, now that routine serum fluoride studies have become possible, the cause-effect relationship has appeared so evident, and the polyuric syndrome

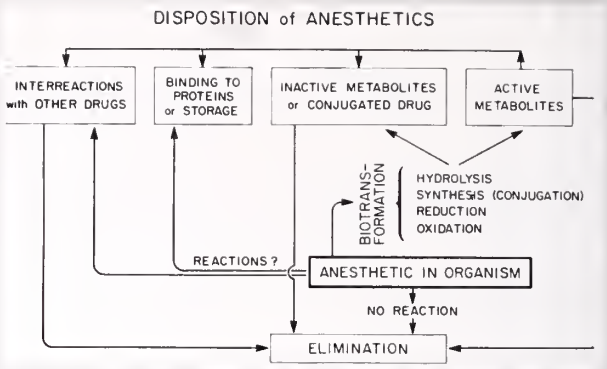

Figure 2. Schematic picture of biotransformation as a part of the process of disposition of anesthetics.

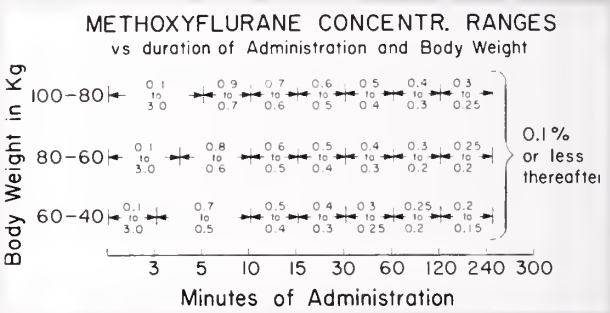

Figure 3. Recommended concentration ranges of methoxyflurane in a 5 liters N_2O/O_2 mixture and in function of body weight and duration of administration.[4]

seems so specific, that little doubt remains on the reality of this syndrome.[5-9]

A second possibility is that perhaps methoxyflurane *per se* is not nephrotoxic but rather its indiscriminate and careless administration is. In fact, the peculiar physical properties of this agent (low vapor-pressure, high blood/gas partition coefficient) and the cardio-vascular stability which occurs during its administration, all give the false impression that it is a "safe" anesthetic allowing high dosages. Yet, methoxyflurane is a very potent agent.[12] No wonder that, for this reason, methoxyflurane has been administered in the past in unnecessarily high quantities. Today we feel that its *dosage* must be reconsidered. In fact, using temperature-calibrated vaporizers and by the routine association of nitrous oxide, pentothal and curarizing agents, the concentrations of methoxyflurane don't need to be high *(Figure 3).* To make easier the prediction and selection of optimal concentrations in function of body weight and of

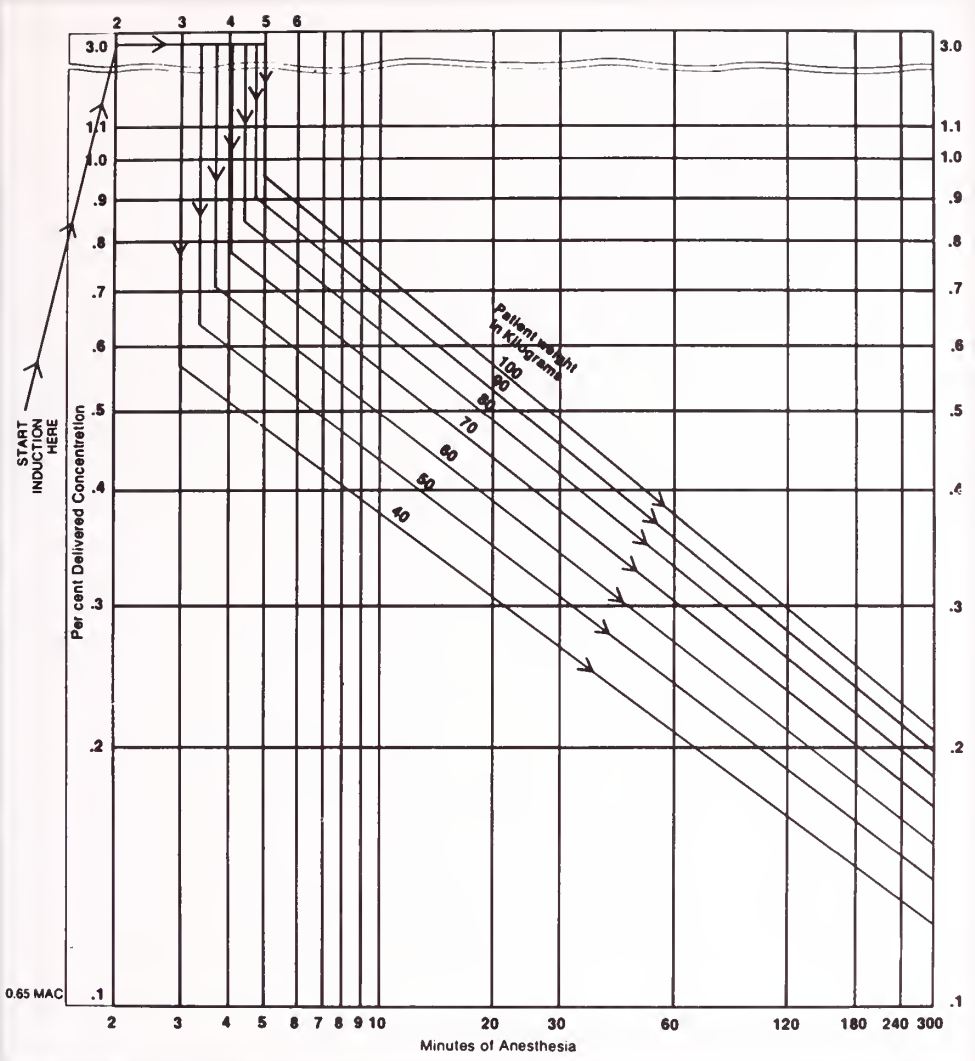

Figure 4. Proposed nomogram [Lowe[13]] to predict the concentration of methoxyflurane in an anesthetic mixture of N_2O/O_2 in function of body weight and duration of administration.

length of administration, a nomogram[13] has been proposed *(Figure 4)*. Under these circumstances, the toxic level of 75 μM/L of fluoride in plasma (corresponding to the administration of a total of 8 ml of liquid methoxyflurane) is seldom overcome *(Figure 5)*, even after a four-hour operation.

At the same time, the *indications* for the selection of methoxyflurane as a major anesthetic must be revised: in particular, methoxyflurane is *not* the agent of choice:

a. in patients with impaired renal function, or who are under treatment with potential nephrotoxic drugs, or in whom fluid and electrolyte imbalance is present.

b. when a surgical procedure which may affect renal function is planned.

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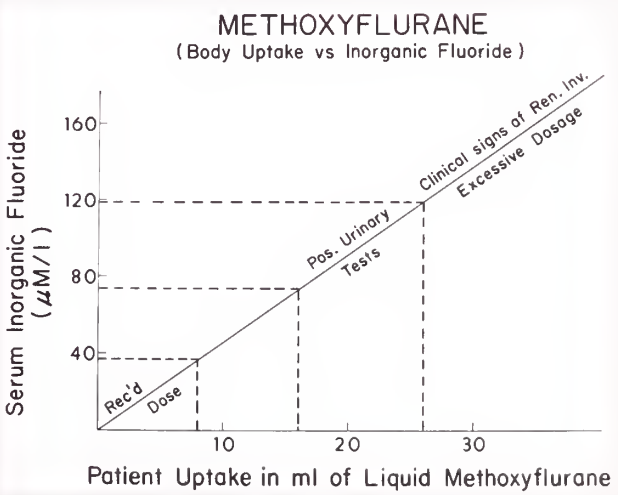

Figure 5. Correlation between serum level of inorganic fluoride, body uptake of methoxyflurane and renal effects.

Monthly Surveillance Report

Cases of Certain Diseases
Reported to the Michigan Department of Public Health
For the four-week period ending Dec. 28, 1973

MICHIGAN DEPARTMENT OF PUBLIC HEALTH

	1973 This 4-Week Period	1972 Same 4-Week Period	1973 Total To Above Date	1972 Total Same Date	Total Cases for 1972
Rubella	59	71	2,001	1,460	1,460
Cong. Rubella Syndrome	2	0	3	1	1
Measles	64	111	4,552	2,353	2,353
Whooping Cough	14	7	86	116	116
Diphtheria	0	0	0	1	1
Mumps	467	471	5,042	3,729	3,729
Scarlet Fever & Strep Sore Throat	3,343	1,982	24,467	13,304	13,304
Tetanus	0	0	1	2	2
Poliomyelitis (paralytic)	0	1	0	1	1
Hepatitis	301	336	3,872	4,322	4,322
Salmonellosis (other than S. typhi)	82	35	795	781	781
Typhoid Fever (S. typhi)	1	0	14	7	7
Shigellosis	54	36	623	574	574
Aseptic Meningitis	20	20	434	266	266
Encephalitis	6	6	163	108	108
Meningococcic Meningitis	6	1	54	55	55
H. Influenza Meningitis	6	8	89	81	81
Tuberculosis	107	92	1,380	1,591	1,591*
Syphilis	311	363	4,328	4,815	4,815
Gonorrhea	2,711	2,054	31,128	24,728	24,728

Information can be supplied by the local health department on the local incidence of disease.

Maurice Reizen, MD, Director
Michigan Department of Public Health

*corrected totals

c. if the surgical procedure lasts more than four hours.

d. in patients who recently received methoxyflurane or other halogenated anesthetics.

e. to obtain muscular relaxation from this sole analgesic in long-lasting operations.

f. to avoid arterial hypotension. (In fact, cardio-vascular stability is a characteristic of methoxyflurane. Absence of cardiovascular signs, therefore, cannot be relied upon as evidence of excessive dosage.)

g. during pregnancy. (Safe use of methoxyflurane has not been established in regard to fetal development. This does not deny the safe use of methoxyflurane for delivery.)

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Perinatal Tips

By Paul M. Zavell, MD

The following case from the files of the Wayne County Medical Society Perinatal Mortality Study Committee is presented as an aid in continuing education.

Maternal

This was the second pregnancy for this 24 year old A-negative white mother. Her first pregnancy ended 15 months previously with a miscarriage after 2½ months. The products of this first pregnancy were examined and said to be quite "abnormal" but no further details are known. During this, her second pregnancy, the mother saw her doctor at regular monthly intervals. Her initial weight was 110 pounds, on a 5 foot 2 inch small body frame, and at delivery her weight had climbed to 144 lbs. She had recorded blood pressures of 140/100 and 130/100 on two occasions after six months with +1 to +2 albuminuria and she had noted sporadic swelling of her ankles. She was treated with bed rest alone and seemed to do well. At about 38 weeks of pregnancy, after arising from bed in the morning, she noted a sudden gush of blood-tinged vaginal fluid. However, since this quickly ceased and was followed only by intermittent and sporadically minimal dripping, and since she had seen her doctor only two days previously and was told "all is well," she felt it unnecessary to call him at this time. Instead she "rested" in bed for the next three days until labor finally began.

The first labor pains were 20-30 minutes apart and quite mild. However, not until 20 hours later were the pains 5 minutes apart and "as instructed" she now called her doctor. He told her to come to the hospital. Once there all labor quickly ceased. After a sterile vaginal examination she was noted to be only very slightly effaced, not dilated, and the baby to be of "adequate size." The following morning labor restarted but poorly. An IV pitocin drip was now started. Six hours later she was only 2-3 cms dilated and less than 50% effaced. An OB consultant was then called in. He felt this mother should have a C Section if she did not deliver in the next few hours. X-rays revealed the baby to be of "good size" and in "good vertex position" and the pelvic outlet to be borderline. Finally, 32 hours after admission to the hospital (but before a C Section could be done) a 10 pound 2 ounce white male infant was born.

Fetal

After birth the initial physical examination done in the delivery room by the obstetrician was considered normal except that bilateral cephalohematomas were noted. Cord blood was A+, 2+ Coombs and 2.0 mgm % total bilirubin. An incubator with heat was the only Rx written. At about 6 hours of age the infant was noted to have some "arching" of the back and appeared somewhat pale. A family doctor who had cared for the mother all her life was then called. He examined the infant at about 9 hours of age and agreed with the previous findings. New orders written included "repeat bilirubin and hemoglobin and 5 liters of oxygen p.r.n. respiratory distress, and Karo water feeding q 3 h." At 10 hours of age the blood results showed total bilirubin of 6.5 mgm %, (indirect of 6.0%) and hemoglobin of 13.0 gm. These results were interpreted as due to cephalohematomas. Repeat studies for the next morning (12 hours later) were then ordered. During the night the infant sucked poorly, seemed to have occasional mild cyanotic spells (helped by oxygen)

(Continued)

The author is a member of the Neo-Natal and Hospital Care Committee, Michigan Chapter, American Academy of Pediatrics, and chairman, Perinatal Mortality Study Committee Wayne County Medical Society.

and continued to arch his back noticeably. In the morning re-examination revealed "slight enlarged liver and spleen." Repeat blood studies (22 hours of age) showed total bilirubin of 11.2 mgm% (10.3 indirect) and hemoglobin of 11.8 gm. A bilirubin photo-light was now ordered.

For the next 24 hours little seemed to change. Repeat bilirubin 25 hours later revealed bilirubin total of 15.3 mgm % (14.2 indirect) and hemoglobin of 11.0 gm. The infant had been started on formula (Enfamil) but still sucked poorly. At about 53 hours of age frequently repeated cyanotic episodes plus intermittent twitching of the extremities began. When the family doctor was called he ordered 15.0 mgm of phenobarbital (¼ gr) I.M. and asked for a pediatric consultant.

One hour later the pediatrician was notified and within an additional hour he came to see the infant. He noted marked arching, moderately severe cyanosis, some respiratory distress and intermittent convulsions (mild). His diagnoses were, "Rh blood incompatibility with possible CNS bleeding." He ordered stat repeat bilirubin, CBC, L.P., IV fluid (5% g/w in 0.5 NS). While he was doing the L.P. the infant had a prolonged convulsion and became very cyanotic. He stopped the procedure and returned the infant to the incubator with oxygen. Despite this color remained poor, extremity twitching persisted and two short generalized convulsions followed. Within 20 minutes the infant expired.

At autopsy subarachnoid hemorrhage, CNS findings suggestive of early kernicterus with blood, liver and spleen findings compatible with Rh incompatibility were found. All cultures were negative for infection.

Perinatal Committee Comments

1. The committee felt that pelvimetry should have been done in this case (especially so since the mother was small and the outlet borderline with at least a normal size [here quite large] infant present).
2. Management of this case would have been easier if the history had stated whether the mother had had Rh-ogram previously or not (obviously in retrospect it was not given).
3. Failure to seek immediate aid with suspected rupture of the membranes places part of the outcome here on the mother since more intensive care of the infant might have then followed.
4. When a large infant is born (especially in a primapara or Gr II or Gr III mother) the mother should be investigated for actual or latent diabetes with a glucose tolerance curve or at least either a fasting blood sugar or a 2 hour postprandial sugar.
5. With an infant having "arching" of the back an L.P. and blood study to rule out hypoglycemia (a blood sugar) should be seriously considered.
6. With twitching of the extremities, blood studies (CA, P, Mg, blood sugar) are in order.
7. In any infant born with an Rh setup (i.e. + Coombs in an Rh infant and Rh mother) and then having both rising bilirubin and decreasing hemoglobulin in the first day or two of birth, an early exchange transfusion should be seriously considered.
8. Although photo therapy for hyperbilirubinemia is accepted therapy in ABO incompatibility and liver immaturity due to prematurity or in small for gestational infants it should not be entirely relied on. There is no substitute for careful and continued monitoring of the infant's physical condition as shown by physical signs and symptoms. When these indicate additional therapy is needed an exchange transfusion is probably needed.
9. When the infant's condition necessitates it, almost all studies (including an L.P.) can be done with the infant remaining in the incubator or isolette rather than transferring the infant to an examining table or the like.

Surgery for Duodenal Ulcer in a Rural Community Hospital

By William D. Baxter, MD, Hastings

The proper surgical procedure for duodenal ulcer disease stirs lively debate. In the last 60 years gastroenterostomy, subtotal gastrectomy and vagotomy and drainage have been advocated. In the last 12½ years the operative procedures in our hospital have gone through considerable change in an effort to achieve lowest mortality and post-operative morbidity and still keep recurrance rate at an acceptable level. Prior to 1963, gastric resection was the primary procedure for duodenal ulcer. After 1963 there was a definite shift in our hospital from gastric resection to vagotomy and pyloroplasty. Since 1968 there has been a tendency to do vagotomy and antrectomy on good risk patients with high ulcerogenic potential.

Material

Pennock Hospital is a 105 bed general hospital in a small rural community. From Jan. 1, 1961, to June 30, 1973, there have been 82 primary procedures done for duodenal ulcer disease. These patients have been studied in detail.

Results

There were 61 (74 per cent) males and 21 (26 per cent) females in the group. Their median age was 48 with a range of 17-80. The indications for operation are summarized in Table 1. Intractability was the major indication.

Table 1

Indication for Operation

Chronic bleeding	6	(7%)
Massive bleeding	13	(16%)
Obstruction	9	(11%)
Acute perforation	6	(7%)
Intractability	48	(59%)
	82	

The author is chief of the department of surgery of Pennock Hospital, Hastings, Mich.

Table 2

Operations

Vagotomy and pyloroplasty or gastrojejunostomy	49	(60%)
Vagotomy and antrectomy	15	(18%)
Subtotal Gastrectomy	10	(12%)
Closure of Perforation	6	(7%)
Gastrojejunostomy	2	(3%)
	82	

The operations performed and their frequency appear in Table 2. Vagotomy and pyloroplasty or gastrojejunostomy were done 60 per cent of the time.

There were 17 additional operative procedures done. Table 3 shows these.

Table 3

Additional Procedures

Hiatus herniorrhaphy	6
Splenectomy	6
Cholecystectomy	5
	17

There was one post-operative death (1.2 per cent). This occurred in a massive bleeder upon whom a vagotomy and pyloroplasty was done. She developed hemorrhagic pancreatitis and died.

17 of the surviving patients (21 per cent) developed one or more post-operative com-

(Continued)

Table 4

Morbidity

Dehiscence	5
Wound Infection	7
Atelectasis and/or pneumonitis	5
Renal failure	1
Peritonitis	1
	19

plications. These complications are compiled in Table 4.

The final test of an ulcer procedure is the recurrence rate. Seventy-five of the surviving 81 (92.6 per cent) have been followed up to 12 years. There have been eight proven or strongly suspected recurrences (9.7 per cent). One of these proved to be a Zollinger-Ellison Syndrome. The recurrence rate of the various operations is shown in Table 5. Both gastric resection and vagotomy and antrectomy have been free from recurrence.

TABLE 5

Recurrence

Operation	no.	Recurrences
Vagotomy and pyloroplasty or gastojejunostomy	49	7 (14.3%)
Vagotomy and antrectomy	15	0
Subtotal gastrectomy	10	0
Gastrojejunostomy	2	1 (50%)
	76	8

Discussion

When choosing the correct operative procedure for the patient with a duodenal ulcer, one must ultimately ask how large a recurrence rate is acceptable in exchange for a low mortality rate. Mortality rates of gastric resection range form 0-12 per cent.[1,2,3,4,8] The average is about 3 per cent. Vagotomy and pyloroplasty mortality rate is definitely lower. It ranges from 0-10 per cent.[2,3,4,8] The average is close to 1 per cent. On the other hand, recurrence after vagotomy and antrectomy (0-3 per cent)[1,2,3,4,8] and gastric resection (2-8 per cent)[4,7] are lower than after vagotomy and pyloroplasty (3-18 per cent).[3,4,5,8] Vagotomy and pyloroplasty has proven the safest procedure for the massively bleeding patient.[6]

The figures in this study would suggest a broadening of the use of vagotomy and antrectomy in good-risk patients while reserving vagotomy and pyloroplasty for massively bleeding, thin, or poor-risk patients. Unfortunately surgeons still lack the ability to predict the minimum operation that will provide protection from recurrence.

Conclusions

Eighty-two primary duodenal ulcer operations were performed in 12½ years. There was a mortality rate of 1.2 per cent, and a recurrence rate of 9.7 per cent. Vagotomy and antrectomy should be done for duodenal ulcer except under special circumstances.

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Hypercalcemia in Neoplasia

By Clarence B. Vaughn, MD, PhD, Southfield

Hypercalcemia is a treacherous complication of malignancy. It is the cause of death in about ten per cent of the patients with neoplastic disease, if multiple myeloma is excluded.[1] This complication frequently is reversible with early diagnosis and prompt and adequate treatment. Proper treatment of this syndrome has allowed many patients to survive months or even years with their disease. The control of the hypercalcemic state also gives the patient the opportunity to respond to therapy directed toward the specific neoplastic condition. This article reviews the standard forms of therapy for elevated serum calcium and also discusses a new substance which has the potential to become an effective hypocalcemic agent.

Table I

Diseases Associated with Hypercalcemia

1. Bone Metastasis
2. Hyperparathyroidism
   a. Primary
   b. Paraneoplastic
3. Blood Dyscrasis
4. Sarcoidosis
5. Vitamin D Intoxication
6. Miscellaneous
   a. Paraplegia
   b. Osteoporosis

Biochemistry of Calcium

In the average adult, the body has 1,160 grams of calcium. Approximately 98-99 per cent of the total quantity of calcium resides in the skeleton locked in a complex crystalline structure. About one per cent of the skeletal calcium is in an exchangeable pool which is in dynamic equilibrium with serum calcium. Calcium absorbed in the alimentary tract is partly deposited in the bone. Whereas mobilized calcium from the exchangeable pool is excreted into the feces via the large bowel and the urine via the kidney. Daily excretion of calcium is 300 to 400 milligrams in the feces and 100 to 200 milligrams in the urine. There is 0.3 grams of calcium in the circulating plasma and clinical values for this divalent action in the serum is 9 to 11 milligrams per cent.

Calcium exists in three forms in the plasma: (1) ionized, (5.5 milligrams per cent); (2) complexed, chelated to organic acids, such as citrate, (1 milligram per cent); and protein bound, especially to albumin, (4.5 milligrams per cent). The ionizeable fraction is responsible for the symptoms of hypercalcemia. Consequently the patient could have symptoms of elevated serum calcium with normal blood values. The increase of the ionizeable fraction could be secondary to low serum albumin or a decrease in the protein bound fraction.

The homeostatic control of serum calcium involves two hormones, parathyroid and calcitonin, and one vitamin, Vitamin D. Hypercalcemia develops whenever the mobilization of calcium from bone exceeds its rate of excretion in the urine and stool. Table I shows a list of diseases which are associated with hypercalcemia.[2]

Bone metastases are the most common cause of hypercalcemia with tumors of the breast, lung and

(Continued)

The author is director of oncology, Providence Hospital, Southfield.

Table II

	Primary Hyperparathyroidism	Pseudo-Hyperparathyroidism	Bone Metastasis
Metastasis*	Absent	Absent	Present
Serum Calcium	Elevated	Elevated	May be normal or elevated
Serum Phosphate	Decreased	Decreased	Normal
Response to Steroids	None	None	Decreased in 20%
Response to effect of tumor treatment	None	Decreased	Decreased

** Metastases were demonstrated by X-ray, bone scan and/or the examination of bone marrow aspirant.*

kidney being the leaders.[2] A paraneoplastic syndrome of hypercalcemia can be produced by tumors manufacturing a parathyroidlike substance.[3] Neoplasms may produce hypercalcemia by the aforementioned two methods. Table II suggests that they can be differentiated by measuring the serum phosphate. A normal value for serum phosphate indicates metastatic disease.

Diagnosis

The presenting symptoms of this metabolic state are nausea and vomiting *(see Table III)*, which are secondary to the inhibition of smooth muscle contractibility. Dehydration becomes a significant factor in the symptomatology because of polyuria and the persistent anorexia. The diagnosis of the syndrome depends upon the measurement of the serum calcium after the clinical findings have raised some suspicion. Table III lists some of the clinical findings which are suggestive of hypercalcemia.[4] Nephrocalcinosis with anuria and cardiac disturbances are the main causes of death in this metabolic condition.[5]

Treatment

The treatment of a hypercalcemic state is worthwhile, even in the presence of widespread malignancy. Controlling the elevated serum calcium will enable the managing physician to direct specific therapy toward the malignancy. The success in controlling this complication of neoplasia, as well as the cancer, has produced a useful prolongation of life.

Hydration

Hydration is effective in about 50 per cent of the cases of hypercalcemia. The effectiveness of this therapy depends on the status of cardiac and renal functions. These patients are treated with four to six liters of normal saline per day while monitoring central venous pressure and the urinary output. Digitalis should be used with caution when administered to a hypercalcemic patient. Potassium should be added to the IV to prevent hypokalemia. Some natriuretic agents also have calciuretic effect.[5] Agents such as furosemide and ethacrynic acid will depress the serum calcium in the adequately hydrated patient.[6] These agents should be used with caution because the induced dehydration can increase the severity of the hypercalcemia.

Table III

Hypercalcemic Syndrome

1. Anorexia
2. Nausea
3. Vomiting
4. Constipation
5. Polyurea
6. Polydipsia
7. Mental Disturbance
8. Visual Disturbance
9. Short QT interval on EKG
10. Nephrocalcinosis

Sulfate

Calciuria is produced by sodium sulfate given by intravenous infusion. An isotonic solution (0.12M)

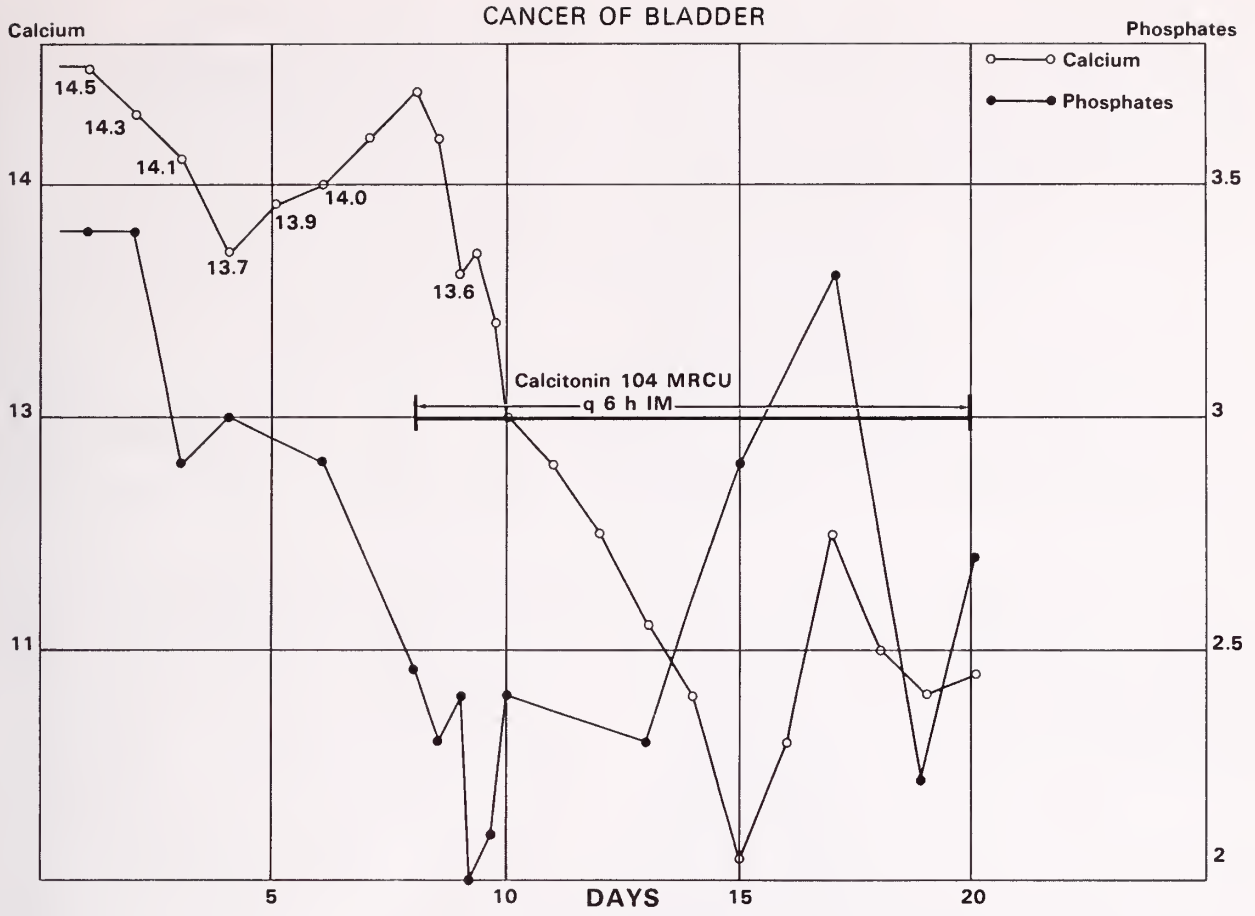

Figure 1

This is a typical graph showing the response of elevated serum calcium levels to Porcine Calcitonin, administered IM every six hours O——O and ●——● represent serum calcium and phospates in mgm% respectively.

is an effective calciuretic agent. This can be considered a form of hydration because approximately five liters of the solution is necessary in controlling hypercalcemic crisis. The drug probably works by producing natriuresis which also augments calcium excretion.[4]

Steroids

Steroids are very effective agents in the treatment of hypercalcemia. They will lower the serum calcium in about 20 per cent of the patients with hypercalcemia secondary to neoplasia. It can be used as adjunct to hydration therapy by adding Solu-Cortef to the intravenous fluid. A dose of this drug, which is well tolerated, is about 300 milligrams a day, or 50 milligrams in each liter of intravenous fluid. Side effects of steroid therapy should be anticipated. There are several medical conditions, namely, peptic ulcer disease and active infections in which the use of steroids are contraindicated.

Mithramycin

Mithramycin is a cytotoxic antibiotic which lowers serum calcium.[7] The mechanism of action of this drug appears to be an inhibition of the osteoclast. The osteoclasts appear to be extremely sensitive to this agent since the dose of Mithramycin to produce hypocalcemia is much lower than that for antitumor activity. One of the drawbacks of this cytotoxic antibiotic is that it limits the use of other types of chemotherapeutic agents. The dose of Mithramycin is 25 micrograms/Kg. Thrombocytopenia, hepatic toxicity, nausea and vomiting has been observed with this agent.

Phosphates

Phosphates have been used effectively in lowering serum calcium in the treatment of hypercalcemia. This anion lost its popularity when it

(Continued)

was discovered that it produced metastatic calcinosis, precipitation of calcium in tissues.[4] However, the oral administration has been used without metastatic calcification in a dose of 50 millimole per day. This form of therapy probably has a place in long-term maintenance of normal serum calcium levels.

Calcitonin

Calcitonin is a recently discovered hormone which has been shown to be effective in lowering elevated serum calcium in humans, but no response in normocalcemic subjects.[8] Isolated porcine calcitonin, 2-8 MRC u/Kg., produces a lowering of serum calcium levels in nine cancer patients with hypercalcemia. Figure I demonstrates a typical response to calcitonin. No side effects from the drug were appreciated within this dose range.

Summary

There are available many methods for treating hypercalcemia successfully. Hypercalcemia, a treacherous complication of malignancy, can be controlled with the proper selection and prompt institution of therapy. Control of this complication will allow the managing physician time to direct definitive therapy toward the malignancy.

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INFORMATION FOR CONTRIBUTORS

1. Address scientific manuscripts to the Publication Committee, Michigan State Medical Society, 120 W. Saginaw St., East Lansing, Mich. 48823. Submit original, double-spaced typewritten copy and two carbon copies or photo copies on letter size (8½ x 11 inch) paper. On page one, include title, authors, degrees, academic titles and any institutional or other credits.

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Commentary

Integrity Is a Rare Commodity

By Kenneth J. Ray, MD, Grosse Ile

In recent medical literature and in the legislatures across the land, no medical term has received more exposure than HMO. By this time, it is patently clear to every informed citizen that an HMO is an organization designed to provide *complete medical care* on a capitation basis. In other words . . . for X dollars per month, one can live comfortably with the allegation that all his medical problems will be solved.

The most prestigious HMO is the Kaiser-Permanente Foundation. In all the literature, it forms the base of reference. Many articles have been printed which affirm the value of this program. These recitations repeat with almost pathological dedication how the HMO concept has resulted in reduced health care costs and a diminished use of in-patient hospital facilities.

These adventures in literature have one thing in common. All were presented by administrators involved in the Kaiser-Permanente project. Whether the source appeared in such authoritative periodicals, as *Fortune Magazine* or the *University of Michigan Hospital Bulletin,* they shared one basic feature: Every article was designed to justify the vocation and convictions of the author, whether he be an MD or a lesser hireling of the administrative structure.

Basically, their reports boil down to a few simple concepts. (Perhaps it would be less kindly and more objective to refer to these as simplistic concepts.) They claim to reduce medical cost by utilizing preventive medicine. In order to make this a sophisticated approach, they developed multiphasic screening, a program in which a patient could talk to a machine instead of a physician. By now, everyone knows that this is an endeavor with no proven worth. After a large investment, those who have experimented with this program have awakened to the fact that this is not a method to discover new diseases; instead, it is merely a practice in "computer therapeutics," giving more comfort to the provider than to the consumer.

Doctor Ray

Apart from this nebulous claim, there are other ways to curb health care costs. One of these is by selecting enrollees so that high risk groups are completely eliminated. The Kaiser-Permanente group has practiced this for some years. Their record is well-documented.

The most effective means of controlling cost is to withhold services. While few professionals accept the concept of preventive care, everyone agrees that withholding medical services is the most effective way to control medical cost. As an example, the Bureau of Health Insurance recognized that following the passage of the Medicare Law they could control the cost by establishing guidelines which restrict the availability of medical services. Even now, some of their seem-

(Continued on Page 106)

Michigan Medicine's new Commentary page will offer physicians and others the opportunity to express opinions on issues in medicine. Contributions are invited and should be submitted to Commentary, *Michigan Medicine,* 120 W. Saginaw St., East Lansing, Mich. 48823.

The views expressed here are those of the author and do not represent positions of the Michigan State Medical Society or opinions of the editors of *Michigan Medicine.*

Reprinted from the Detroit Medical News, Jan. 14, 1974.

Robert M. Leitch, MD, of Battle Creek, MSMS Council chairman, presides over general session of leadership conference held Dec. 19 in Ann Arbor.

Leadership Conference Draws 90 Physicians

Despite southern Michigan's first snow storm of the season, 90 physicians journeyed to Ann Arbor Dec. 19 for a leadership conference sponsored by MSMS. Major presentations were given by Brooker L. Masters, MD, MSMS president, and John J. Coury, MD, immediate past president.

Workshop sessions considered professional liability, peer review and component society activities. Leo Brown, assistant to the AMA executive vice president, was the luncheon speaker.

Daniel Fall, MD (left), of Ann Arbor, chairman of MSMS Ad Hoc Committee on Peer Review Systems, and Robert E. Rice, MD, of Greenville, chairman of MSMS Committee on Governmental Medical Care Programs, lead discussion on peer review systems.

Leo Brown, of Chicago, assistant to the AMA Executive vice president, addresses luncheon session.

John W. Grigg, MD (left), chairman of the MSMS Committee on Professional Liability Insurance, leads well attended panel session covering insurance problems faced by Michigan physicians, aided by A. Stewart Kerr, MSMS Legal counsel from Detroit.

Frederick Van Duyne, MD, of Flint, president of Genesee Medical Corp., discusses corporation's experience during session on peer review.

Photos by Stuart Abbey, Ann Arbor.

Mediscene

Feb. 21-24—Seminar and ski weekend arranged by the Continuing Post Graduate Psychiatric Education Program at Wayne State University, at Shanty Creek Lodge, Bellaire, for physicians and spouses, contact: Leon E. A. Berman, MD, Detroit Psychiatric Institute, 1151 Taylor Ave., Rm. 151 B, Detroit, Mich. 48202.

Feb. 28-March 1—Postgraduate seminar, International Medical Assembly of Southwest Texas in San Antonio, contact: S.E. Cockrell, Jr., executive director, IMAST, 202 W. French Pl., San Antonio, Texas 78212.

March 7—Professional Activity Study and Medical Audit Program Institute, sponsored by Commission on Professional and Hospital Activities, at CPHA headquarters, Ann Arbor, AAFP elective hours, contact: CPHA, 1968 Green Rd., Ann Arbor, Mich. 48105.

March 13—MSMS Council, MSMS Headquarters, contact: Warren F. Tryloff.

March 14-15—23rd annual postgraduate course in pediatrics, University of Texas Medical Branch, Galveston, contact: Lillian H. Lockhart, MD, Department of Pediatrics, University of Texas Medical Branch, Galveston, Texas 77550.

March 14-16—Postgraduate course in "Current Concepts in Obstetrics and Gynecology," University of Kentucky Medical Center, Lexington, contact: Ronald D. Hamilton, MD, Director, Continuing Education, College of Medicine, University of Kentucky, Lexington, Ky. 40506.

March 15-16—Second Annual National Conference on Human Nutritional Aspects of Kidney Disease and Renal Failure sponsored by the Kidney Foundation of Michigan, Michigan Renal Dietitians and the Michigan State University School of Nutrition, at Kellogg Center, MSU, East Lansing, contact: Ms. Jean Bruge, Michigan Nephrology Center, Borgess Hospital, 1521 Gull Rd., Kalamazoo, Mich. 49001.

March 18-21—Physician postgraduate course "Rheumatic Disease: Pathogenesis, Diagnosis and Treatment," sponsored by American College of Physicians, at U-M Medical Center, Ann Arbor, contact: ACP, 4200 Pine St., Philadelphia, Pa. 19104.

March 18-23—Continuing education course in laryngology and bronchoesophagology, sponsored by the Department of Otolaryngology, Abraham Lincoln School of Medicine, University of Illinois, and the Eye and Ear Infirmary, U of I Hospital, in Chicago, contact: Dept. of Otolaryngology, Eye and Ear Infirmary, 1855 W. Taylor St., Chicago, Ill. 60612.

March 19-22—Symposium and winter workshop sponsored by the American College of Emergency Physicians, in New Orleans, contact: ACEP office, 241 E. Saginaw St., East Lansing, Mich. 48823.

March 26-27—Colposcopy seminar, University of Kentucky Medical Center, Lexington, contact: Ronald D. Hamilton, MD, Director, Continuing Education, College of Medicine, University of Kentucky, Lexington, Ky. 40506.

March 25-28—Second annual spring meeting, featuring eight postgraduate courses, sponsored by the American College of Surgeons, in Houston, contact: ACS, 55 E. Erie St., Chicago, Ill. 60611.

March 27-28—Annual Michigan Conference on Maternal and Perinatal Health, the Pantlind Hotel, Grand Rapids, contact: Lloyd Kammeraad, MD, 1810 Wealthy St., SE, Grand Rapids, Mich. 49506, or Helen Schulte, MSMS Headquarters.

March 29-31—Continuing medical education workshop in human sexuality sponsored by the Michigan Psychiatric Society in collaboration with the Department of Psychiatry, Sinai Hospital, Detroit, at Sinai Hospital, accredited by the American Academy of Family Physicians, AMA accreditation requested, contact Ms. Diane Fleming, Registrar, Room 228 Blumberg Professional Bldg., 14800 W. McNichols Rd., Detroit, Mich. 48235.

March 31-April 6—Introductory course in "Functional Corrective Surgery of the Nasal Septum and the External Nasal Pyramid," "Rhinomanometry and Naso-antral Manometry" and "Basic Principles of Respiratory Physiology and Fundamental Diagnostic Tests," sponsored by the American Rhinologic Society and the Illinois Masonic Medical Center, Chicago, at the center, contact: R.P. Gustafson, Illinois Masonic Medical Center, 836 Wellington Ave., Chicago, Ill. 60657.

April 11—Ninth Annual Conference on the Medical Aspects of High School Sports, sponsored by MSMS, at Grand Valley State College, Allendale, contact: Helen Schulte, MSMS Headquarters. *(Note a new date and location for the conference.)*

April 18-20—Critical care symposium on "Pulmonary Function and Blood Gas Changes in Critically Ill and Injured Patients," sponsored by the Department of Surgery of the Wayne State University School of Medicine at the Wayne County Medical Society Headquarters, 1010 Antietam,

Detroit, contact: Robert F. Wilson, MD, FACS, Professor of Surgery, WSU School of Medicine.

April 24—Annual Legislative Day, MSMS Auxiliary, at Olds Plaza Hotel, Lansing, contact: Mrs. Robert J. Westerhoff, 2458 Maplewood, SE, Grand Rapids, Mich. 49506.

April 24-25—Annual Spring Conference, MSMS Auxiliary, at Hospitality Inn, Lansing, contact: Mrs. William J. Jones, president, 15839 Crescent Drive, Allen Park, Mich. 48101.

April 25-27—27th National Conference on Rural Health sponsored by the AMA Council on Rural Health at the Detroit Hilton Hotel, contact: Bond L. Bible, PhD, Department of Rural Health, AMA, 535 N. Dearborn St., Chicago, Ill. 60610.

April 25-28—Annual convention, American Association of Medical Assistants, State of Michigan, Detroit Hilton Hotel, contact: Virginia Doyle, 1484 Southfield Rd., Birmingham, Mich. 48009.

April 28-May 3—Annual conference of the National Council on Alcoholism, sponsored by the NCA and its affiliates, in Denver, contact: Mrs. Ann Milata, NCA, 2 Park Ave., New York, N.Y. 10016.

April 29-May 2—Twenty-second Annual Clinical Meeting of the American College of Obstetricians and Gynecologists, Las Vegas, contact: Donald F. Richardson, Associate Director, ACOG, 1 E. Wacker Dr., Chicago, Ill. 60601.

May 1-3—Annual meeting of the Michigan Public Health Association, Detroit Hilton, contact: Anna Lampela, MPHA, 403 Seymour Ave., Lansing, Mich. 48914.

May 2-3—Annual session and scientific program, Michigan Heart Association, Cobo Hall, Detroit, contact: Michigan Heart Association office, 16310 12 Mile Rd., Southfield, Mich. 48076.

May 5—MSMS Council, Boyne Falls, contact: Warren F. Tryloff.

May 5-7—1974 Annual Session, MSMS House of Delegates, at Boyne Mountain Lodge, Boyne Falls, contact: Richard Campau, MSMS Headquarters.

May 9-10—Seventeenth Annual Clinic Days of Children's Hospital of Michigan, postgraduate meeting on pediatric infectious diseases, cosponsored by the Wayne State University School of Medicine, contact: Adnan Dajani, MD, Children's Hospital of Michigan, Detroit Medical Center, 3901 Beaubien Blvd., Detroit, Mich. 48201.

May 10-11—Seventh Annual Cancer Symposium, on "Management of Ovarian Malignancy," sponsored by the Wayne State University School of Medicine in co-sponsorship with the American Cancer Society—Michigan Division and the Michigan Cancer Foundation, at Gordon Scott Hall, WSU Medical School, contact: Mrs. Dorothy Bewley, Cancer Symposium Registrar, 4160 John R St., Detroit, Mich. 48201.

May 18-25—Annual Michigan Week, sponsored by the Greater Michigan Foundation, with 15,000 volunteers taking part, for information on events, contact: Greater Michigan Foundation, 809 Center St., Lansing, Mich. 48905.

May 24-25—Thirteenth Annual Kidney Disease Symposium sponsored by the Kidney Foundation of Michigan in cooperation with Henry Ford Hospital, in Buerki Auditorium, Detroit, contact Nathan W. Levin, MD, chairman, Kidney Foundation of Michigan, 3378 Washtenaw Ave., Ann Arbor, Mich. 48104.

June 1-5—Advanced continuing education workshop on "Plastic Surgery of the Aging Face," sponsored by the Department of Otolaryngology. Abraham Lincoln School of Medicine, University of Illinois, in cooperation with the American Academy of Facial Plastic and Reconstructive Surgery in Chicago, contact: Department of Otolaryngology, Eye and Ear Infirmary, 1855 W. Taylor St., Chicago, Ill. 60612.

June 12—MSMS Council, MSMS Headquarters, contact: Warren F. Tryloff.

June 16-20—AMA House of Delegates and Clinical Convention, Chicago, contact: AMA, 535 N. Dearborn St., Chicago, Ill. 60610.

June 16-27—1974 Summer Program in Human Sexuality, sponsored by the Indiana University Institute for Sex Research, in Bloomington, Ind., contact: Institute for Sex Research, 416 Morrison Hall, Indiana University, Bloomington, Ind. 47401.

July 6-10—Michigan Academy of Family Physicians Annual Meeting and Scientific Program, Park Place Motor Inn, Traverse City, contact: MAFP office, 933 Wing St., Plymouth, Mich. 48170.

Aug. 1-3—MSMS Council, St. Clair Inn, St. Clair, contact: Warren F. Tryloff.

Sept 23-27—Family practice review, sponsored by the Michigan Academy of Family Physicians, at Scott Hall, Wayne State University School of Medicine, contact: MAFP office, 933 Wing St., Plymouth, Mich. 48170.

Sept. 25—MSMS Council, MSMS Headquarters, contact: Warren F. Tryloff.

Oct. 9-10—109th Scientific Session, sponsored by MSMS, at the Sheraton-Cadillac Hotel, Detroit, contact: Helen Schulte, MSMS Headquarters.

Nov. 6—MSMS Council, MSMS Headquarters, contact: Warren F. Tryloff.

Dec. 11—MSMS Council, MSMS Headquarters, contact: Warren F. Tryloff.

Education

Physicians, Students Praise Primary Care Preceptorships

Ninety-five per cent of the 282 Michigan medical students who participated in the Cooperative Michigan Primary Care Preceptorship Program during its first year reported increased interest in becoming primary care physicians as a result of the experience.

Ninety-eight per cent of the students said they enjoyed the program and would recommend it to other students, and 97.4 per cent of the 272 physicians who served as preceptors said they too enjoyed taking part. Of the students, 95 per cent reported that they would recommend their preceptors to others.

These reports from participants were compiled by the Michigan State University College of Human Medicine in evaluating the program, in which medical students spent four or more weeks assigned to physicians to observe office based medical practice. Financed through a federal grant, the program operates on an around the year basis and is designed to encourage student interest in careers in primary care.

Physicians are being sought to serve as preceptors in the coming year according to Alegro J. Godley, MD, director of the Division of Family Medicine at Wayne State University. He asked that interested doctors direct inquiries either to him or to Esly Caldwell, MD, assistant professor in the Division of Family Medicine.

Wayne, MSU and the University of Michigan all participate.

Most of the physicians who have been in the program since it began last year said that students' presence in their offices did not cut into their time with patients. Time available to patients actually increased for 27.4 per cent of the physicians, MSU reported. No effect on the physician's time commitment to patients was reported by 47.7 per cent. In reporting on students' activities, 97.1 per cent of the physicians said that students' physical examination findings were verified as accurate, and 84.6 per cent of the physicians found special projects carried on by the young men and women interesting.

Well over half of the preceptorship programs have been in cities with populations of less than 50,000, scattered throughout the state. The accompanying tables show geographic distribution and town size for the 1973 programs.

Student Assignments According to Population

Size of City of Placement	Number of Students
Under 2,500	38
2,500-10,000	80
10,000-50,000	54
50,000-100,000	32
100,000-500,000	38
Over 500,000	39
Unreported	1

Geographic Distribution of 1973 Preceptorships

Area	Number of Students
Upper Peninsula	27
Petoskey	1
Cheboygan	2
Traverse City	15
Huron National Forest	3
Cadillac	4
Bay City	6
Grand Rapids	26
Lansing	12
Flint	5
Thumb	5
Pontiac	6
Detroit Suburbs	70
Kalamazoo	10
Battle Creek	10
Jackson	2
Ann Arbor	31
Adrian	8
Detroit	39

Blue Shield Offers 200 Student Loans

Michigan Blue Shield has announced an immediate start for its new loan program for junior and senior medical students as a result of state action to permit the move.

Blue Shield informed MSMS of the plan more than a year ago. Delay in getting it under way was due to legal problems that now have been solved.

Blue Shield will guarantee up to 200 loans a year, with a maximum of $5,000 each, through Michigan banks for junior and senior medical students who agree to practice in Michigan once their education is completed. Students who enter medical practice in areas designated as short of physicians will be required to repay only principal, with Blue Cross paying interest on their loans.

U-M Announces New Program in Mental Retardation

Applications are being accepted for a new two-year graduate program for physicians in mental retardation and related disabilities established by the Maternal and Child Health Section of the University of Michigan School of Public Health.

This is one of only two such programs in the country, according to Arthur W. Fleming, MD, U-M professor and director of the new program. "The program is intended to develop the special skills and knowledge important to a physician wishing to provide the needed medical direction to involved organizations," explained Doctor Fleming.

The program includes nine months of academic work at the U-M School of Public Health, fulfilling the requirements for the degree of master of public health, followed by 12 or more months of training that will include intensive experience in clinical, administrative and community organization aspects of services.

Present admission requirements specify completion of an approved residency program in pediatrics or psychiatry and interest in working with handicapped children. Fellowships are available for selected students.

Requests for additional information about the program should be addressed to Ruben Meyer, MD, Director Maternal and Child Health Programs, or to Arthur W. Fleming, MD, Director, Training Program in Mental Retardation and Related Disabilities, School of Public Health, University of Michigan, Ann Arbor, Mich. 48104.

U-M Lists Schedule of Courses in PG Medical Education

Following is a listing of courses in postgraduate medical education to be offered in winter and spring by the Department of Postgraduate Medicine and Health Professions Education of the University of Michigan. All of the courses will be at the U-M Medical Center, Ann Arbor, unless otherwise noted.

Feb. 26-March 1	*Emergency Medicine*
March 7 & 8	*Advances in Pediatrics*
March 11	*Feto-Maternal Monitoring, Advanced*
March 12	*Feto-Maternal Monitoring, Basic*
March 14 & 15	*Vascular Surgery*
March 22	*Occupational Therapy Program in General Hospitals*
March 26-28	*Electrocardiographic Diagnosis*
March 27	*Realignment of Roles: Physician, Nurse Practitioner, Physician's Assistant*
April 8-10	*Ob-Gyn Conference*
April 8-May 3	*Surgical Anatomical Review*
April 17-19	*Neuroendocrine Integration: Basic and Applied Aspects*
April 25	*Pathology Seminar*
May 1 & 2	*Glaucoma Conference*
May 2 & 3	*Consultative Process Workshop*
May 7 & 8	*Symposium on the Biology of Cancer*
May 8 & 9	*Therapeutics*
May 17	*Basic Burn Care*
May 21-24	*Advances in Internal Medicine*
June 3-5	*Advances in Clinical Neuroscience*
June 6-7	*Blood Banking*
June 13 & 14	*Pulmonary Disease Workshop*
June 24-28	*Northern Michigan Summer Course, Bellaire*

Inquiries should be directed to Robert K. Richards, Director, Office of Intramural Education, Department of Postgraduate Medicine, Towsley Center, Ann Arbor, Mich. 48194.

Ophthalmology research in animals is yielding knowledge that can be applied to human medicine. Above, W. F. Keller, DVM, chairman of the Department of Small Animal Surgery and Medicine at Michigan State University's College of Veterinary Medicine, examines a Pekingese.

Veterinary Research Makes Contributions to Knowledge of Human Disease

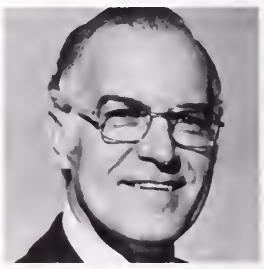
By Judith Marr

Sickle cell anemia in deer, atherosclerosis in swine and diabetes in dogs currently are under study by veterinarians, with important implications for physicians in Michigan and throughout the world who treat humans with the same diseases.

These studies loom along "one of the most exciting new horizons for veterinary medicine as a profession—the development of animal models of human disease," according to the congenial, distinguished dean for 16 years of the Michigan State University College of Veterinary Medicine.

"I'm not talking of manufacturing the diseases in animals," elaborates Dean W. W. Armistead, DVM, "but of the identity of naturally-occurring diseases in animals which turn out to be similar to those in man and provide us with ready-made experimental animals in which to study these diseases."

At the same time that veterinarians are increasing their research in human diseases, they also are working increasingly with physicians and basic science researchers on important medical projects, Dean Armistead reports.



Dean Armistead

"The team approach is the thing now," he says. "The roles of veterinarian and physician on joint research projects may vary widely. Either MD or DVM may plan the research, and the other assist.

"The lone operator is really a thing of the past. Problems today are so much more sophisticated."

Dean Armistead points out that "we've got to know more about the new animals that are just now being used in laboratory experiments. One of

Veterinary medicine students at MSU examine a feline patient at the school's Veterinary Clinic. MSU veterinarians and physicians are working together in a comparative anesthesiology project.

Animal surgery is another area in which new knowledge to benefit humans is being sought.

them is the armadillo, the first animal in which researchers have succeeded in inducing leprosy. We've got to know their normal blood chemistries, life spans and urinalyses, for example.

"All of these details simply are going to have to be worked out. When you multiply them by hundreds of diseases and hundreds of animals, there's an enormous task ahead of us."

The veterinarian is the expert on the team with this particular vital knowledge and it is to him that the physician and basic science researcher thus turn.

Indeed, it was veterinarians at work before World War II, Dean Armistead says, who pioneered the use of pins to repair broken bones. It was a Viennese veterinarian seeking to escape the kicks of cows who first developed a spinal anesthesia, and a Canadian DVM, studying sweet clover poisoning in cattle, who did the work preliminary to the development of the anticoagulant dicumarol, now used to prevent heart attacks in man.

Today's greatest man-killers—cancer, heart disease and the infirmities of old age—are shared by animals, often in almost identical form, Dean Armistead continues. In fact, most human ailments can be found in correlative forms in species of so-called lower animals.

A Florida veterinarian recently identified more than 250 diseases and abnormalities of man which have counterparts in animals. More than 100 infectious diseases are transmissible between animals and man.

(Continued on Page 104)

Mrs. Gail Peel (left), a technician at the MSU Veterinary Clinic, explains use of an isolette to a student.

Medicine Needs Creditability Based on Deeds, Not Promises

Doctor Chalat

By Ned I. Chalat, MD, President, Wayne County Medical Society

(The following is excerpted from a speech given by Doctor Chalat before Greater Detroit Area Hospital Council members' public relations directors.)

My own attitudes about public relations and the medical profession's relationship to it have changed a great deal in the last few years, as have those of society in general.

My father was a physician here in Detroit, a general practitioner. He had offices in the Maccabees Building. He worked as a city physician which meant that he made house calls for the poor in what were then called "slums." He made many house calls. He also attended a free clinic at Receiving Hospital. My father seemed to care little about his clothing, his car, or even his health for that matter. He worked very hard, at all hours, in homes and in hospitals. Whenever he went out, he was greeted with "Hi, Doc!" from all sides. He was, thus, the "before" image of Dr. Blankenship created by George Bernard Shaw, in the play, "The Doctor's Dilemma." One look at him, and you knew that he was the personification of the man the Medical Society's public relations people would like to project as the "doctor." Today, however, many of the opportunities that our fathers had to create this image are no longer available to us. The practice of medicine has become so complex that considering emergency care, or care of the very sick, in the home is ludicrous. To make a diagnosis by looking thoughtfully at a patient's urine in a glass bottle before a light, or smelling his breath, or the squeezing of an ankle would be simplistic. The hospital's so-called "free clinic" is no longer free. Through government and insurance, the opportunity of the physician to give charity through service has largely disappeared. As the scientific methods replace, to a degree, bedside manner we inject a matter of remoteness through which we become suspect. Small wonder, therefore, that our relations today might be considered "pejorative," rather than public.

Further complicating these situations is the fact that we live at a time when all institutional credibility is questioned. This applies, as you know, to the hospitals, the physicians, the press, educational institutions, government, business, law, the judicial system and on and on. Indeed, there are many who today imply that there is no longer any creditability for our institutions and there will be none. This is a very frightening thought, and, obviously, I do not believe it is true. I do, however, realize that the time given to us to be of influence through the Medical Society may perhaps be too short to succeed completely in turning these attitudes around.

However, we would like *with your help* to make a beginning. How can be hope to do this? First; we have to admit that problems exist and second; present ourselves in a position of openness with a willingness to listen, to accept suggestion and seek solutions. Input is needed from all areas, especially from our public relations people who will become at once our liaison with the public and our planning consultants. I feel the administrators of the hospitals need to upgrade their public relations departments. Then we all together may initiate the development of new programs. We need help in developing new ideas, in shaking off natural resistance to change, in projecting the proper timing, proper phraseology and in assuring exposure in the areas where the ideas can flourish. We must rely upon the public relations departments, in the hospitals particularly, to act in cooperation for the mutual good of the patient and the profession, and to identify areas for advertising and salesmanship. Most physicians tend to think of "the media" as meaning two newspapers and three television channels. However, there are more than two papers, there are many channels through the state

(Continued on Page 114)

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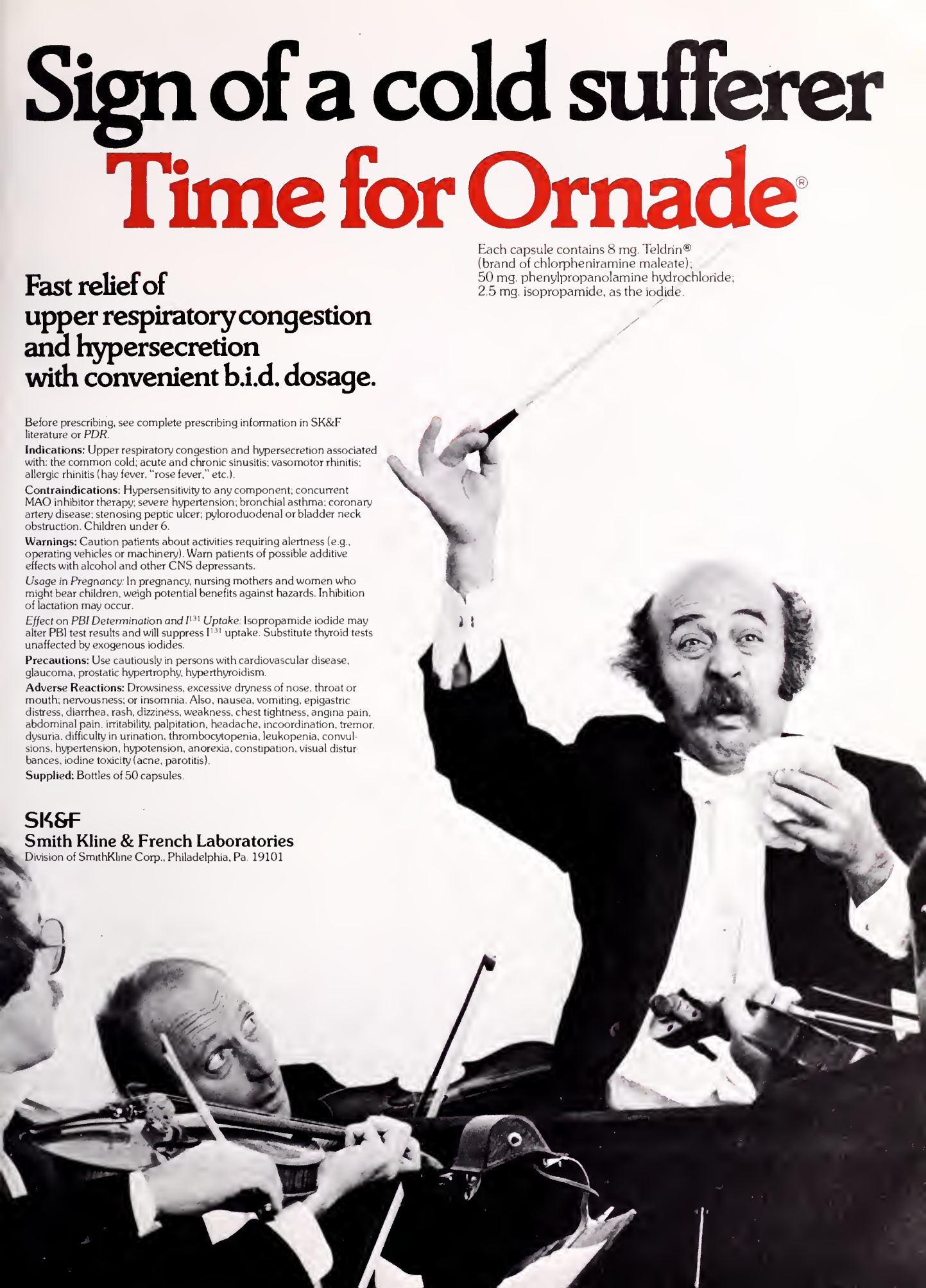

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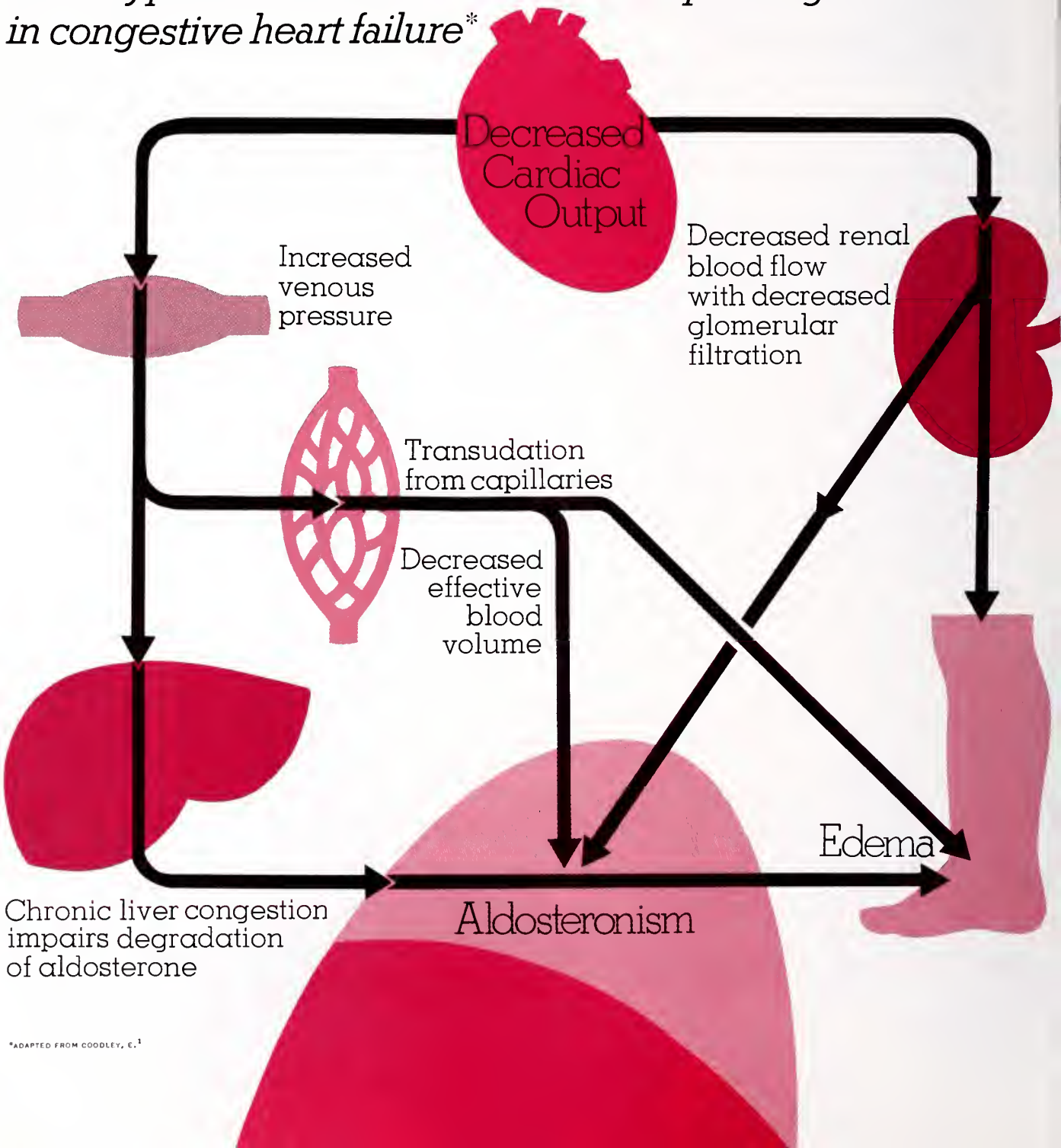
*How hyperaldosteronism leads to and prolongs edema in congestive heart failure**



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- Can be administered daily as basic therapy with the additional agent (furosemide or ethacrynic acid) given every second or third day.
- Aldactone plus "A.D.D." schedule minimizes potassium deficiency and potentiates effect of "add-on" diuretic.[2]
- Avoids acute volume depletion and aldosterone rebound.[2]

3. As a daily diuretic in combination with a daily dose of a thiazide

- Permits daily additive diuretic effect while maintaining potassium balance.

Indications—Essential hypertension; edema or ascites of congestive heart failure, cirrhosis of the liver and the nephrotic syndrome; idiopathic edema. Some patients with malignant effusions may benefit from Aldactone (spironolactone), particularly when given with a thiazide diuretic.

Contraindications—Acute renal insufficiency, rapidly progressing impairment of renal function, anuria and hyperkalemia.

Warnings—Potassium supplementation may cause hyperkalemia and is not indicated unless a glucocorticoid is also given. Discontinue potassium supplementation if hyperkalemia develops. **Usage of any drug in women of childbearing age requires that the potential benefits of the drug be weighed against its possible hazards to the mother and fetus.**

Precautions—Patients should be checked carefully since electrolyte imbalance may occur. Although usually insignificant, hyperkalemia may be serious when renal impairment exists; deaths have occurred. Hyponatremia, manifested by dryness of the mouth, thirst, lethargy and drowsiness, together with a low serum sodium may be caused or aggravated, especially when Aldactone is combined with other diuretics. Elevation of BUN may occur, especially when pretreatment hyperazotemia exists. Mild acidosis may occur. Reduce the dosage of other antihypertensive drugs, particularly the ganglionic blocking agents, by at least 50 percent when adding Aldactone since it may potentiate their action.

Adverse Reactions—Drowsiness, lethargy, headache, diarrhea and other gastrointestinal symptoms, maculopapular or erythematous cutaneous eruptions, urticaria, mental confusion, drug fever, ataxia, gynecomastia, inability to achieve or maintain erection, mild androgenic effects, including hirsutism, irregular menses and deepening voice. Adverse reactions are infrequent and usually reversible.

Dosage and Administration—For **essential hypertension** in **adults** the daily dosage is 50 to 100 mg. in divided doses. Aldactone may be combined with a thiazide diuretic if necessary. Continue treatment for two weeks or longer since an adequate response may not occur sooner. Adjust subsequent dosage according to response of patient.

For edema, ascites or **effusions** in **adults** initial daily dosage is 100 mg. in divided doses. Continue medication for at least five days to determine diuretic response; add a thiazide or organic mercurial if adequate diuretic response has not occurred. Aldactone dosage should not be changed when other therapy is added. A daily dosage of Aldactone considerably greater than 75 mg. may be given if necessary.

A glucocorticoid, such as 15 to 20 mg. of prednisone daily, may be desirable for patients with extremely resistant edema which does not respond adequately to Aldactone and a conventional diuretic. Observe the usual precautions applicable to glucocorticoid therapy; supplemental potassium will usually be necessary. Such patients frequently have an associated hyponatremia—restriction of fluid intake to 1 liter per day or administration of mannitol or urea may be necessary (these measures are contraindicated in patients with uremia or severely impaired renal function). Mannitol is contraindicated in patients with congestive heart failure, and urea is contraindicated with a history or signs of hepatic coma unless the patient is receiving antibiotics orally to "sterilize" the gastrointestinal tract.

Glucocorticoids should probably be given first to patients with nephrosis since Aldactone, although useful for diuresis, will not directly affect the basic pathologic process.

For **children** the daily dosage should provide 1.5 mg. of Aldactone per pound of body weight.

References: 1. Goodley, E.: Consultant 12: 106-107, 109, 111, 113, 115 (July) 1972. **2.** Thorn, G. W., and Lauler, D. P.: Am. J. Med. 53: 673-684 (Nov.) 1972

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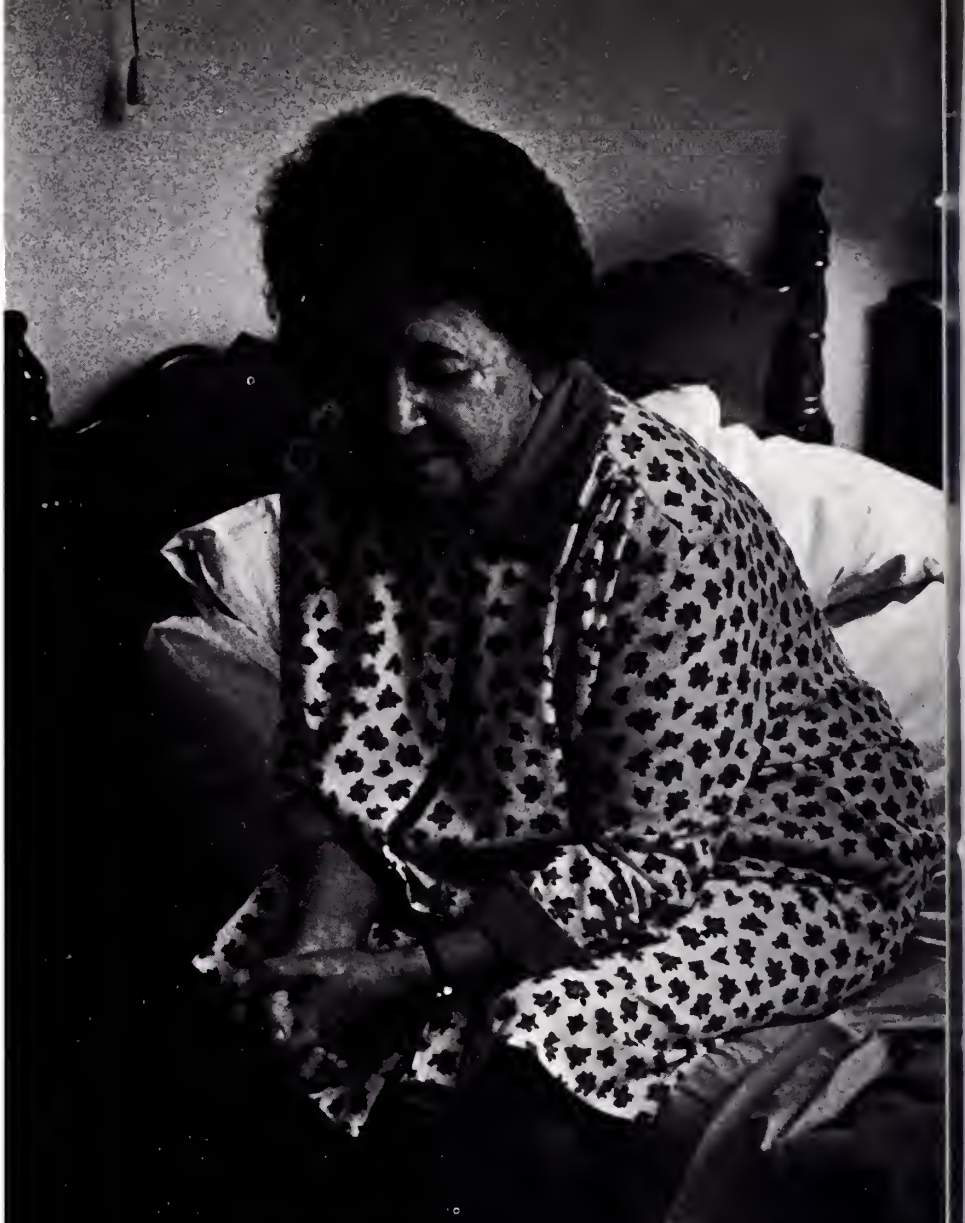

Placidyl®
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Brief Summary

Indications—Placidyl (ethchlorvynol) is indicated as short-term hypnotic therapy in the management of insomnia.

Contraindications—Drug hypersensitivity and porphyria.

Warnings—Not recommended during the first and second trimester of pregnancy. Caution patients of possible combined exaggerated effects with alcohol, barbiturates, tranquilizers or other CNS depressants. Exaggerated effects might result in blurring of vision, paralysis of accommodation and profound hypnosis. Caution patients concerning driving a motor vehicle, operating machinery, or other hazardous operations requiring alertness after taking the drug. ADMINISTER WITH CAUTION TO PATIENTS WITH SUICIDAL TENDENCIES AND DO NOT PRESCRIBE LARGE QUANTITIES OF THE DRUG. Adjustment of the dosage of oral anticoagulants might be necessary when beginning ethchlorvynol therapy, during therapy, or after stopping therapy. This drug is not recommended for use in children. PLACIDYL HAS THE POTENTIAL FOR THE DEVELOPMENT OF PSYCHOLOGICAL AND PHYSICAL DEPENDENCE. INSTANCES OF SEVERE WITHDRAWAL SYMPTOMS, INCLUDING CONVULSIONS AND DELIRIUM CLINICALLY SIMILAR TO THOSE SEEN WITH BARBITURATES, HAVE BEEN REPORTED IN PATIENTS TAKING REGULAR DOSES AS LOW AS 1000 MG. PER DAY OVER A PERIOD OF TIME WHEN THE DRUG WAS SUDDENLY DISCONTINUED. PROLONGED ADMINISTRATION OF THE DRUG IS NOT RECOMMENDED. Addiction-prone patients or those who are likely to increase dosages of the drug on their own initiative should be observed for evidence of signs or symptoms which may indicate possible early withdrawal or abstinence symptoms. Signs and symptoms associated with withdrawal and abstinence include unusual anxiety, tremor, ataxia, slurring of speech, memory loss, perceptual distortions, irritability, agitation and delirium. Other less well defined signs and symptoms, not necessarily due to withdrawal and abstinence, may include anorexia, nausea or vomiting, weakness, dizziness, sweating, muscle twitching and weight loss. Abrupt discontinuance of Placidyl following prolonged overdosage may result in convulsions and delirium.

Precautions—Toxic amblyopia has been reported with long-term continuous use of ethchlorvynol. Permanent visual defects have been observed, although amblyopia has improved after discontinuation of the drug. Drug dosage should be limited for elderly and debilitated patients to the smallest effective amount. If pain is present, this drug should only be given if insomnia persists after pain is controlled with analgesics. Caution is advised in prescribing the drug for patients who are being treated with either MAO inhibitors or antidepressants. Transient delirium has been reported with the combination of Placidyl and amitryptyline. Drug dosage should be reduced if prescribed for patients receiving MAO inhibitors or antidepressants. Caution should be exercised in patients with impaired hepatic or renal function. Patients who respond unpredictably to barbiturates or alcohol, or who exhibit excitement and release of inhibition in association with such agents, may also react in this way to Placidyl. Rarely, patients may exhibit symptoms suggestive of an unusual susceptibility to the drug; such as prolonged hypnosis, profound muscular weakness, excitement, hysteria, or syncope without marked hypotension. Transient giddiness or ataxia may occur.

Adverse Reactions—Hypotension, nausea or vomiting, gastric upset, aftertaste, blurring of vision, dizziness, facial numbness, and allergic reaction typified by urticaria have been reported following Placidyl administration. Mild "hangover" and symptoms of mild excitation have occurred in some patients. There have been rare reports of cholestatic jaundice occurring in patients taking ethchlorvynol. A few cases of thrombocytopenia have been reported in patients receiving ethchlorvynol. 305432

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Briefly Noted

Ali A. Abbasi, MD, of Clawson,

received an honorable mention award for medical photography in the 1973 Medical Art Award Competition sponsored by the Student American Medical Association and Eaton Laboratories. Doctor Abbasi is on the staff of the Veterans Administration Hospital in Allen Park.

Arnold R. Axelrod, MD, of Oak Park,

professor of medicine at the Wayne State University School of Medicine, recently was appointed chairman of the department of medicine at Sinai Hospital, Detroit. A member of the WSU faculty since 1949, Dr. Axelrod is a distinguished hematologist and the author of numerous scientific articles. He is a graduate of the WSU medical school, served his residency at Detroit General Hospital and became a member of the WSU faculty in 1949.

Michael J. Brennan, MD, of Grosse Pointe,

president of the Michigan Cancer Foundation, has announced that the foundation has received a $361,000 contract from the National Cancer Institute to expand cancer information and reporting systems and establish communication links to local, state and national health organizations.

Juan V. Fayos, MD, of Ann Arbor,

is the new president of the Michigan Society of Therapeutic Radiologists. Other new officers are Murray Boles, MD, of Detroit, president-elect, and Delmar Mahrt, MD, of Royal Oak, secretary-treasurer. The society meets bimonthly during the academic year and membership is open to radiologists interested in therapeutic radiology from Michigan, Canada and neighboring states. Interested physicians may contact Doctor Mahrt at the Department of Therapeutic Radiology, William Beaumont Hospital, Royal Oak.

Ray Helfer, MD, of East Lansing,

was selected by the Lansing State Journal as one of 11 Lansing men noted for outstanding achievement during 1973. Doctor Helfer, professor of human development at Michigan State University was cited for publication of his second book on child abuse, *Helping the Battered Child and His Family*. He also assisted in the development of counseling classes for parents at the Ingham Medical Community Mental Health Center in Lansing.

Robert E. James, MD, of Flint,

is the new president of the Genesee, Lapeer, Shiawassee County Chapter of the American Academy of Family Physicians. Doctor James is a graduate of the University of Colorado Medical School and is a former chief of staff at Hurley Hospital in Flint.

Charles B. Overbey, Jr., MD, of Kalamazoo,

has retired as assistant superintendent of the Kalamazoo State Hospital after 27 years as a member of the hospital's staff. Doctor Overbey was graduated from the University of Oklahoma School of Medicine in 1941 and is certified by the American Board of Psychiatry and Neurology.

Harry C. Pennington, MD, of White Pigeon,

retired recently from medical practice after 40 years as a practicing physician in southwestern Michigan. A reception in his honor was given by the staff of Sturgis Hospital.

Ernst A. Rodin, MD, of Detroit,

has been named president-elect of the American Electroencephalographic Society. The society will conduct a three-day course in clinical electroencephalography and hold its 28th annual meeting July 22 to 27th in Seattle.

Eugene Rontal, MD, and Michael Rontal, MD, of Detroit

describe facial injuries they say are caused by football helmets and face masks in an article in the November-December, 1973, issue of *Transactions*, official journal of the American Academy of Ophthalmology and Otolaryngology. The article, written by the Detroit physicians and Kent Wilson, MD, of Minneapolis, notes that "The full-cage mask provides the greatest amount of protection currently available."

Welcome

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

Aftab A. Aftab, MD, 10118 Clio Rd., Clio, 48420
Earl W. Campbell, MD, B220 Life Science Bldg., Dept. of Medicine—MSU, East Lansing, 48824
Nancy W. Dever, MD, 100 Michigan St., NE, Grand Rapids, 49503
Donald G. Dimcheff, MD, St. Joseph Hospital, Ann Arbor, 48104
Saul Z. Forman, MD, 21415 Civic Center Dr. #117, Southfield, 48076
Luther L. Fry, MD, Grace Hospital, Detroit, 48201
James R. Jett, MD, 347 Bostwick, NE, Grand Rapids, 49503
Stephen Kalstein, MD, G-1071 N. Ballenger Rd., Flint, 48504
Jerome F. Kasle, MD, G-1071 N. Ballenger Rd., Flint, 48504
S. A. Majid Kazerooni, MD, 6405 Telegraph Rd. D-1, Birmingham, 48010
Martin W. Kleiman, MD, 231 North Ave., Battle Creek, 49017
John A. Koivunen, MD, 77 Third St., Laurium, 49913
Chandulal B. Malde, MD, 2710 W. Court St., Flint, 48503
Linda B. Maxwell, MD, 213 Sidewinder, K. I. Sawyer AFB, 49843
R. Richard Maxwell, MD, 213 Sidewinder, K. I. Sawyer AFB, 49843
Joseph R. Meerschaert, MD, 3535 W. 13 Mile Rd. #302, Royal Oak, 48072
Ronald A. Moss, MD, Central Michigan Community Hospital, Mt. Pleasant, 48858
Sadrudin L. B. Musani, MD, 2710 W. Court St., Flint, 48503
Yong Hwa Park, MD, 620 Byron Rd., Howell, 48843
Vijay Saigal, MD, 32411 Glen Cove Apt #1, Farmington, 48024
Linda C. San Antonio, MD, 15700 Providence Dr. #718, Southfield, 48075
George A. Schaub, MD, 2764 Holyoke Lane, Ann Arbor, 48103
Kripa Shankar Singh, MD, Box A, Ypsilanti, 48197

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James R. Driver, M.D.
Robert L. Fransway, M.D.
Stuart M. Gould, Jr., M.D.
Sydney Joseph, M.D.
Hubert Miller, M.D.
Jacob J. Miller, M.D.
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Certainly we can tell our patients individually, and we must do that. But this issue demands more than that.

Probably 95 per cent of the people have no idea what an HMO means, but it needs to be pointed out, in language they can understand that the only way an HMO can save money is by restriction of services. It needs to be pointed out that doctors have always done peer review; that possibly it doesn't take a billion dollar bureaucratic watchdog to make peer review more effective. Why not admit it is spotty and ask for specific complaints so we can make corrections? Or does incentive need to be taken away just because health care also is caught in our horrible inflationary spiral. The positive points are almost endless.

We need to do something and soon. Our present efforts cannot be effective enough. But the makers of policy will listen to the wishes of the voting populace. Really, don't they need, or deserve, what we are trying to save for them: the highest quality and most available medical service on the face of the globe?

I want every doctor to publicly stand for the best medical care. I also want the true facts of what health care really is to come out, for public consumption. Right now, this seems to be one of the most available ideas to accomplish this.

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Would you let me know your reaction or suggestions by return mail? I shall confess that it would be heart warming to learn that a few hundred of you are concerned enough to respond. With that kind of awareness, I feel that today need not be a fore-warning of doom, but a reaffirmation of faith in the future.

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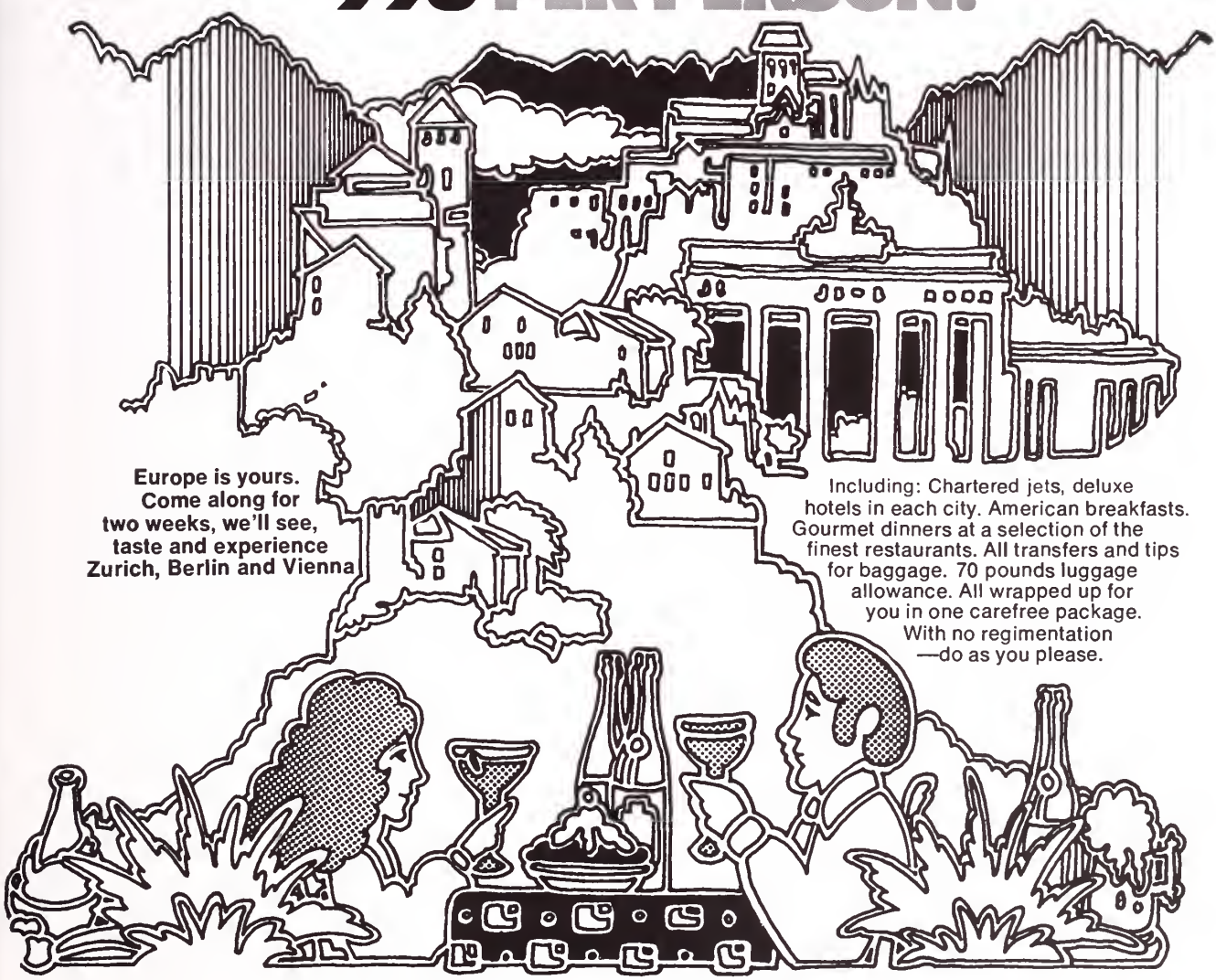

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"Hence it is with animals that much of the research on human ailments can be done most productively," he says. "And, obviously, to draw valid conclusions from research you have to start with healthy, well-nourished animals whose genetic backgrounds are known."

A whole new area of research, called laboratory animal medicine, has been evolving during the last 10 to 15 years, Dean Armistead reports, while the whole area of animal-based research has been undergoing a great growth of importance.

Drawing the veterinarian more closely into the medical research picture, he says, have been the humane movement, state and federal laws promulgating care of research animals and most particularly the FDA. More and more, the Food and Drug Administration is requiring adequate pretesting for efficacy, standardization and lack of toxicity of a new drug, vaccine or food additive before licensing. This pretesting is most done practically with animals.

Dean Armistead says veterinarians have not sought to shoulder their way onto medical research teams. "This development has been evolving of its own. We are not taking an aggressive stance, but more of an informational attitude."

More and more, medical schools are employing veterinarians on their faculties. They are establishing facilities such as the Center for Laboratory Animal Resources at MSU, which has one of the nation's newest medical schools and one of its most prestigious veterinary medical schools.

The MSU Center, a pioneer when established in 1967 and since then widely copied throughout the U.S., is staffed primarily by veterinarians. Their responsibilities are to see that the care of laboratory animals on campus meets minimum standards and to be available for advice to researchers on diagnosis, treatment, and the best animals to use in a particular study.

MSU veterinary medicine students examine a canine patient under supervision of a faculty member.

A "fair sampling" of faculty members at the MSU veterinary school is at work on projects related to human disease, though relatively few graduates of the school go into such research yet, Dean Armistead says. "But the numbers are growing because the opportunities are so great."

At MSU, veterinarians and physicians are working together in a strong cardiovascular research effort, on a comparative anesthesiology project and on plans for a surgical research unit to be administered and funded jointly by the human, veterinary and osteopathic medical schools. Some veterinary medical students act as support in cardiac surgery at Lansing's Ingham Medical Hospital.

Through the MSU Anatomy Department, a nucleus of the various medical disciplines currently is working on developmental defects, while other research is underway on the East Lansing campus on blindness in hatchery-raised brook trout, neonatal calf mortality and blood diseases in animals, all with the goal of learning more about how to prevent and treat such conditions in man.

These are typical of the medical research projects on which veterinarians and physicians now find themselves working jointly, Dean Armistead says.

Current statistical projections are for a shortage of 4,000 veterinarians nationally in 1980, or for just 38,000 DVMs when 42,000 will be needed. There now are about 27,000 veterinarians in the U.S.

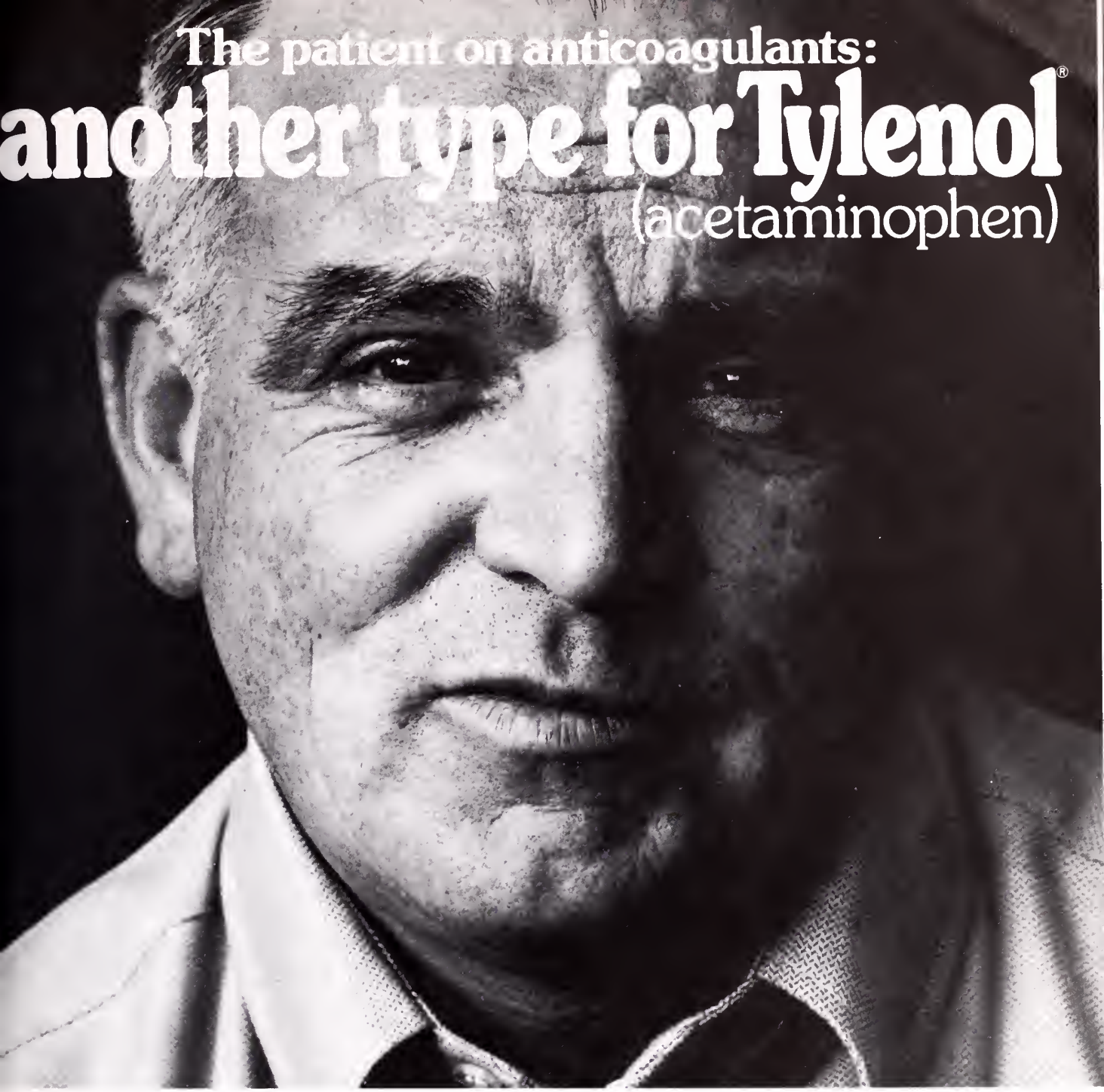
But Dean Armistead thinks the projections fall short, because "they have not taken into account the brand-new areas just opening now, particularly the growing involvement of veterinarians in basic medical research and in research for the direct benefit of human health," which he rates as one of the six biggest new trends in his profession during the past 15 years.

"I think we are going to have a shortage far down the road," he says.

For, according to a report Dean Armistead drew up last September for the Association of American Veterinary Medical Colleges, ". . . the greater role of veterinary medicine (is) as a practical necessity to the public health.

"Modern veterinary medicine has the same objectives as does human medicine: the improvement of human health and welfare . . . veterinary medicine is devoted primarily to the prevention of human illness and to the protection of human health through improvement of man's environment."

The patient on anticoagulants: another type for Tylenol® (acetaminophen)



When the patient on anticoagulant therapy has a condition requiring an analgesic, a new problem arises. Aspirin frequently causes prolonged bleeding time and occult gastrointestinal bleeding.[1,2]

TYLENOL (acetaminophen) however, is unlikely to produce either reaction[2,3] and is therefore the preferred analgesic for the patient with hemorrhagic tendencies and the patient receiving anticoagulant therapy.

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References: 1. Koch Weser, J., and Sellers, E.M.: New Eng. J. Med. *285*:447-458 (Sept. 2) 1971. **2.** Udall, J.A.: Clin. Med. *77*:20-25 (Aug.) 1970. **3.** Mielke, C.H., Jr., and Britten, A.F.H.: New Eng. J. Med. *282*:1270 (May 28) 1970 (corresp.).

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ingly practical and perhaps realistic decisions are being challenged in the courts.

In this editorial, we shall confine ourselves only to the concept of withholding services, which sometimes masquerades under the very sophisticated term of "under-utilization." This issue has many ramifications but in this instance, we will confine ourselves to the HMO, which creates an enviable record by withholding services.

This is particularly important since the Kaiser-Permanente group has made an issue of their splendid record of hospital admissions (utilization) compared to their neighboring community hospitals.

A few months ago, my good friend, Doctor Harvey Gass, inferred that all was not well in Nirvana. His communication indicated that neurosurgical patients with papilledema could not gain admission to a Kaiser-Permanente hospital "because they would die anyway." In spite of the high reliability of the informant, nothing could be reported without verificaton from a primary source. After some effort, this information was verified in a direct communication, dated Oct. 18, 1973, with the letterhead of Kern General Hospital. This letter will be quoted generously in the text that follows.

Doctor Robert Raskind served as the Chief of the Department of Neurological Surgery for the Kaiser Foundation Hospital in Oakland from October, 1959, until early in 1970. During these 11 years of service, he developed an insight which few of us have. He saw the HMO at work with its intricacies and lax integrity. This is the game of the sophisticate in our society who plays the system to gain points and ignore basic honor. In candid terms, it might be called The Medical Watergate, which somehow each of us has permitted to flourish under a veil of ignorance.

For the sake of background, it is interesting to quote directly from Doctor Raskind's letter: "During my initial experience with the organization, I had a free hand in running a first-rate neurosurgical service in a hospital equipped with a complete house staff and most of the operating instruments but totally inadequate, as far as angiography and other neurodiagnostic procedures were concerned. When I came, I had been promised that I would get all the necessary equipment 'as the budget allowed.'

"During the next several years, although I still had a free hand in patient care, diagnostic facilities were not forthcoming . . . but for several years, they were allowing us to use the Neuroradiology Department at the University of California Hospital, San Francisco, and this—though troublesome—was adequate."

Finally, Doctor Raskind's letter gets down to the issue of demonstrating how the withholding of services is implemented, even dictated, by the actuarial powers that engineer the system.

"Starting in the latter part of 1969 at the time some internal power struggle was taking place, it was decided to cut back in surgery. As a matter of fact . . . in the early part of 1970, I received a formal directive from my immediate superior that all surgery had to be cut back 20 per cent . . . also, that the desperately ill patients, so often seen on a neurosurgical service, were so expensive that it was cheaper to let these patients die. This went on to the point that patients I had scheduled and other members of my department had scheduled were cancelled by the front office, simply for budgetary reasons. The entire thrust of the prepaid plan was to show that they were doing less than half the amount of surgery done in the surrounding community hospitals. This, to some extent, was altered and influenced by the fact that the patients who were refused adequate medical care from the surgical standpoint at the Kaiser Foundation Hospital ended up having their surgery done elsewhere."

As an extension of this low utilization philosophy, Doctor Raskind reports, "Procedures such as abortion and sterilization were not covered under the Kaiser Health Plan at that time. In the event any of their patients wanted to have these procedures done, they could pay a private rate separate from their basic enrollment cost. Even then, they were urged to go elsewhere so that again the overall surgical total could be reduced."

One of the prime claims of Clifford Keene, MD, President of the Kaiser-Permanente Foundation, has been dedication to scientific and medical research. Doctor Raskind was urged to expand the boundaries of current medical capability. To quote from his letter: "One of the comments made by a superior, who noted that we were spending upward of 100 hours a week in the operating room was 'Instead of all this surgery, you fellows should learn to prevent brain tumors.' I think that this would be a good trick, but I had no way of doing it at the present time."

The world will not be shaken by the words that appear in a single small journal but at the least, it should alert our members to view statistical reports at arm's length. Everything may not be as it appears on the surface.

The government has supported many programs, but their wisdom may be less than the collective knowledge of the sincere professional. It is appropriate that all these federal programs be analyzed and evaluated on the basis of facts supplied by such as Doctor Raskind and others, who dare to defy the establishment that lies.

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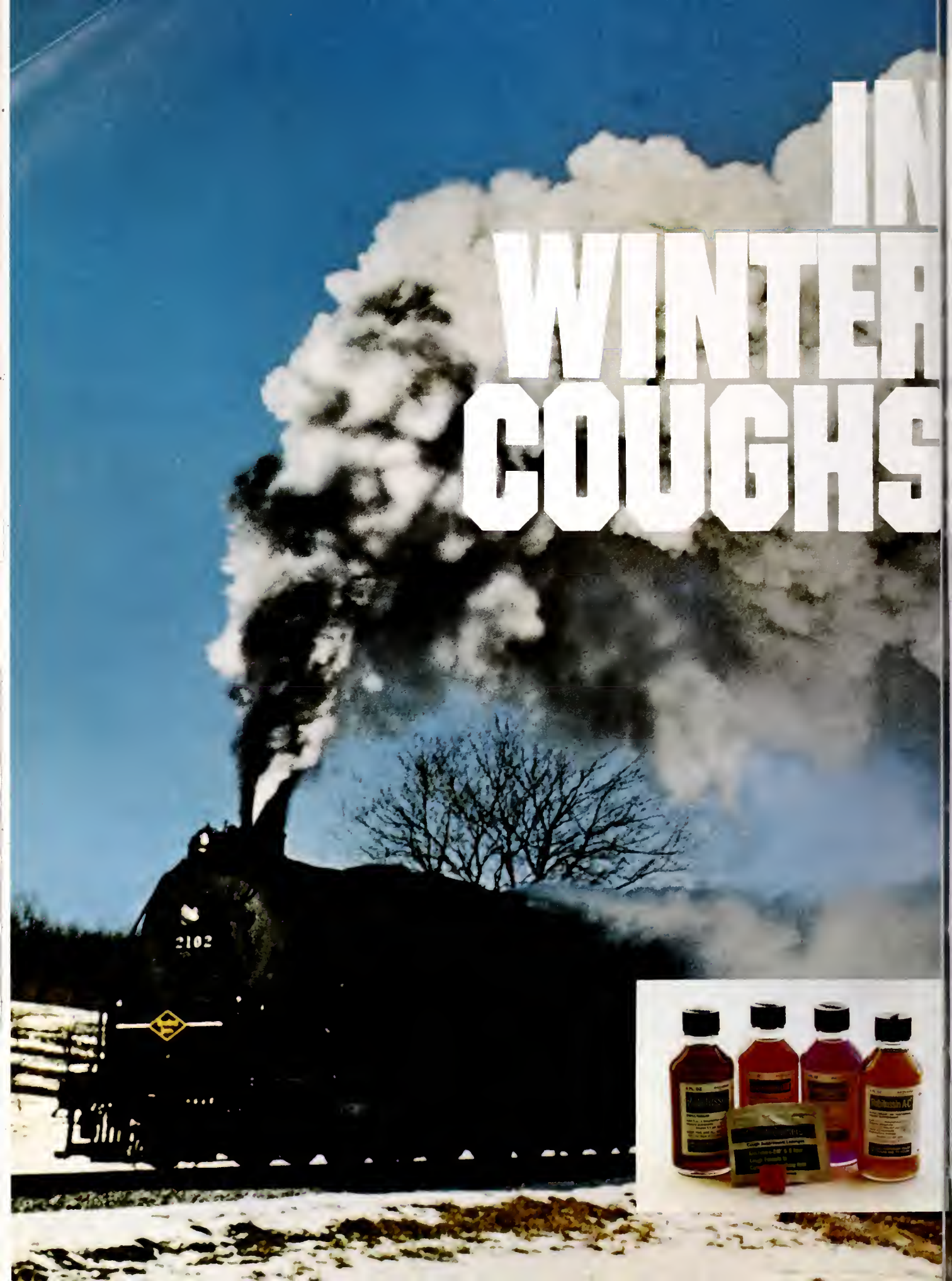
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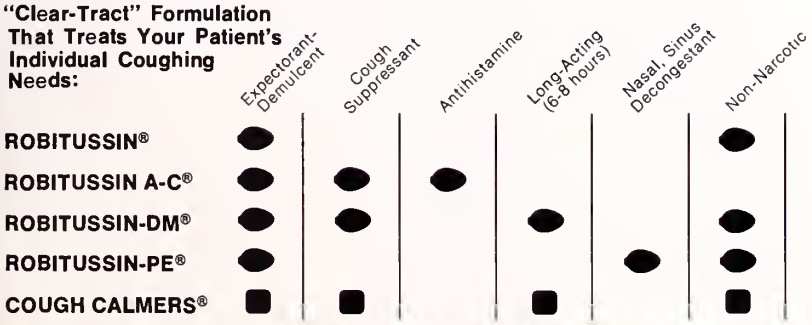

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The Weight of Professional Opinion

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The American Academy of Dermatology

The Board of Directors of the American Academy of Family Physicians

The Executive Board of the American Academy of Neurology

The Committee on Drugs of the American Academy of Pediatrics

The American College of Allergists

The Executive Committee of the American College of Obstetricians and Gynecologists

The Board of Regents of the American College of Physicians

The Board of Trustees of the American Dental Association

The Board of Trustees of the American Medical Association

The American Psychiatric Association

The Executive Committee of the National Association of Retail Druggists

The Board of Directors of the Pharmaceutical Manufacturers Association

The National Wholesale Druggists' Association

Joint Statement on Antisubstitution Laws and Regulations

The purpose of this statement is to affirm the support of the participating organizations for the laws, regulations and professional traditions which prohibit the unauthorized substitution of drug products.

Traditionally, physicians, dentists and pharmacists have worked cooperatively to serve the best interests of patients. Productive cooperation has been achieved through mutual respect as well as a common concern for the ideals of public service. This mutual respect has been reflected, in part, by joint support over the years for the adoption and enforcement of laws and regulations specifically prohibiting unauthorized substitution and encouraging joint discussion and selection of the source of supply of drug products. The basic principles of medical, dental and pharmacy practice are thus utilized and preserved in the interest of patient welfare.

The antisubstitution laws have not obstructed enhancement of the professional status of pharmacy any more than they have in and of themselves guaranteed absolute protection from unsafe drugs, or freed physicians, dentists and pharmacists from their responsibilities to patients. As a practical matter, however, such laws and regulations encourage interprofessional communications regarding drug product selection and assure each profession the opportunity to exercise fully its expertise in drug usage, to the advantage of patients.

Physicians and dentists should be urged to increase the frequency and regularity of their contacts with pharmacists in selection of quality drug products, recognizing that economies to patients can be improved through such communication, taking into account the patients' needs. The pharmacist's knowledge of the chemical characteristics of drugs, their mode of action, toxic properties and other characteristics that assist in making drug selection decisions should be utilized to the fullest extent practicable by physicians and dentists in serving their patients.

Since drug product selection entails knowledge derived from clinical experience, the physician's and dentist's roles in product selection remain primary and do not permit delegation of decisions requiring medical and dental judgments. A broader role in therapy will evolve for pharmacists as improved understanding and cooperation among the professions continue to grow.

There has been no evidence that there are convincing reasons to modify or repeal existing laws and regulations prohibiting the unauthorized substitution of another drug product for the one specified by a prescriber. It is our belief that such laws and regulations merit the joint support of the medical, dental and pharmaceutical professions and the pharmaceutical industry.

Add your opinion to the weight of other professionals and send it to your state assemblyman or legislator.

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and of course, there is the radio which we have tended to neglect. And most important, there is local exposure through placards and word-of mouth.

In preparing for this speech, I spent time searching areas where mutual support and cooperation are indicated. It is immediately apparent that we come together most often, most directly, undoubtedly most significantly, with the patient. Here our ideals, idealism, and wishes are identical.

There is a need to mutually identify techniques for mediating grievances. I tell each new employee, in our offices, that people are at their worst when they become ill. Sickness descends as an immensely frightening spector when one becomes ill unexpectedly. No one can prepare completely for an illness. There is fear, pain, anxiety, threat to the ego and financial discomfort as at no other time in our lives. Much of the anger and frustration that develops cannot be directed either inwardly or at members of the family who are similarly threatened. The hospital and the physician are very often placed in a position of jeopardy. Our Medical Society has three committees, that meet regularly, to mediate and adjudicate problems, I suspect that without mutually orientated committees, i.e., committees sponsored by both the hospital and the physician, there may be a tendency for each of us to blame the other, albeit unconsciously. Thus, we work counter to the purposes of the medical profession. I would suggest, therefore, that cooperative committees within the hospital, indeed within regional areas, be set up to mediate grievances. This may be a committee back-up to the *Ombudsman* technique that is being used at several local hospitals.

There have been many recent developments within our own profession, which will require patient education. These include the Professional Standards Review Organizations, continuing education efforts on the part of both the hospital and the Medical Societies, the impacts of the cost of delivery of health care, the fact that we in the medical profession are anxious to recruit, as full members, the residents and interns in your hospitals. There are the cooperative efforts needed because of the Cost of Living Council regulations. There are problems created by Phases I, II, III and IV of the President's inflation containment program. There is the ever present need to improve relations with the mass media. I had intended to bring today a small pamphlet entitled "Guidelines for Physicians in their Relations with the Communications Media," published by the Judicial Council of the AMA. I am hopeful that you will read it and familiarize yourselves with the contents. I know that many physicians are not clear about what they may and may not divulge. Many are confused about the differences between public domain and privileged information. Communication, here, with knowledge, is undoubtedly a valuable tool.

I have brought, I hope, enough copies of the recently much publicized "Bill of Rights of the Patient" for which many hospitals have begun seeking the approval of the medical staff for publication. Recently also, through the Cleveland Academy of Medicine and the Cleveland Hospital Association, there has been developed a "code of cooperation" that I think could be important. I would like you, if possible, to know about it, to know its contents, and perhaps give us some in-put concerning whether you think this would be a reasonable project for our area. It is a cooperative effort between the press, the hospital, and the local medical profession to clarify some of the difficulties that we have been talking about. I think that mutually we can establish other local projects, for example; emergency call systems, poison control programs, anti-food-fad campaigns, immunization programs, disaster preparedness plan and local MD placement and recruitment services. We can further help to organize local charity drives in support of special projects. An example is the recently very popular "Tennis and Crumpets" program which has contributed to the Burn Unit at Children's Hospital. There are many hospitals that will need support for Intensive Care Units, Cardiac Care Units and other special projects. There is a need for inter-hospital cooperation of the auxiliary and voluntary groups, a need for cooperation between the Wayne County Medical Society, the hospital, the medical schools, the Medical Center. We need to provide house staff living placement, language studies and social outlets, especially for foreign students and immigrants.

Last of all, I suspect that to the American public, public relations is surfacing as a previously sleeping giant might. The experiences with national elections must demonstrate the fearful potential that sophisticated techniques in advertising and personality projection or assassination may accomplish. It is a fearful spector. Creditability in America must in the future be based on deeds rather than on promises and on fact rather than fancy. Therefore, it will be imperative that we cooperate, that we not lose our spirit of idealism, that we consider always what is best for the patient and that we become personally more introspective in our own role as to what we ourselves are, and can be, rather than simply what image we wish to project.

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1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

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Possibly Effective:

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Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

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Arthur L. Amolsch, MD
Detroit

Arthur L. Amolsch, MD, 86, a pathologist who practiced in the Upper Peninsula and in Detroit, died Jan. 28 in Detroit. He recently had moved to Detroit from Marquette, where he was a member of the staffs of St. Luke's and St. Mary's Hospitals. He also had been on the staff of Francis A. Bell Memorial Hospital in Ishpeming.

He was a graduate of the Detroit College of Medicine and had served as an instructor there. Doctor Amolsch was a past president of the Michigan Society of Pathologists and of the Marquette-Alger County Medical Society.

Morton Barnett, MD
Birmingham

Morton Barnett, MD, 59, a clinical assistant professor of psychiatry at the Wayne State University School of Medicine, died Jan. 1. Doctor Barnett had been a member of the Wayne faculty since 1944.

Doctor Barnett received his medical education at Wayne State. He was a member of the staffs of Providence and Oakwood Hospitals and also was in private practice in Oakland County. He was a past president of the Detroit Psychoanalytic Society and Institute, a fellow of the American Psychiatric Association and a member of the American Psychoanalytic Association.

Hugh L. Dill, MD
Detroit

Hugh L. Dill, MD, 76, a Detroit physician for 48 years, died Jan. 1. Doctor Dill was graduated from the Detroit College of Medicine and the Detroit College of Pharmacy.

He was a former mayor and councilman in Grosse Pointe and a past president of the University Club.

W. Harold M. Johnson, MD
Detroit

W. Harold M. Johnson, MD, of Detroit, died Jan. 26 at the age of 80. Doctor Johnson was born in Chatham, Ontario, and was graduated from the Detroit College of Medicine. He practiced in Detroit for 57 years and founded the former Trinity Hospital in 1938.

He was a life member of the Michigan State Medical Society.

Roy A. MacNeill, MD
Kalamazoo

Roy A. MacNeill, MD, of Kalamazoo, died Jan. 1 at the age of 77. Doctor MacNeill was graduated from the University of Michigan Medical School.

He had practiced in Kalamazoo for more than 30 years before his retirement in 1971.

Carleton J. Marinus, MD
Detroit

Carleton J. Marinus, MD, of Detroit, died Jan. 7 at the age of 80. Doctor Marinus, a specialist in endocrinology, was graduated from the University of Michigan Medical School in 1921.

George A. Zindler, MD
Bellevue

George A. Zindler, MD, of Bellevue, a physician in Battle Creek for 40 years, died Jan. 21 at the age of 64. Doctor Zindler was a graduate of the Northwestern University School of Medicine and specialized in internal medicine.

In Battle Creek, Doctor Zindler was on the staffs of Community and Leila Y. Post Montgomery Hospitals and Battle Creek Sanitarium. He also had served on the medical faculties at Wayne State University and the University of Michigan.

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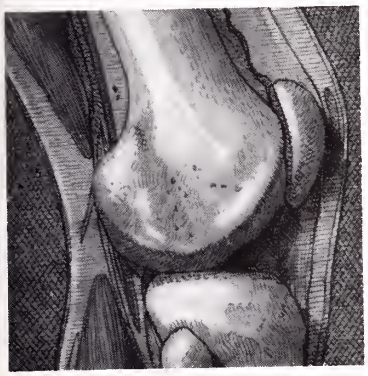

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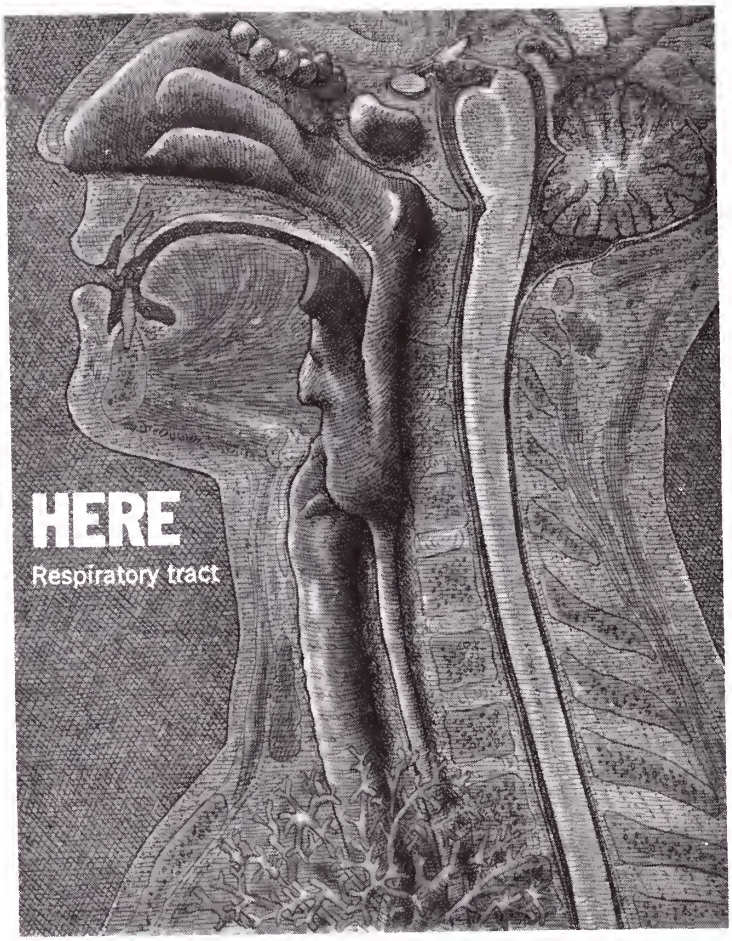

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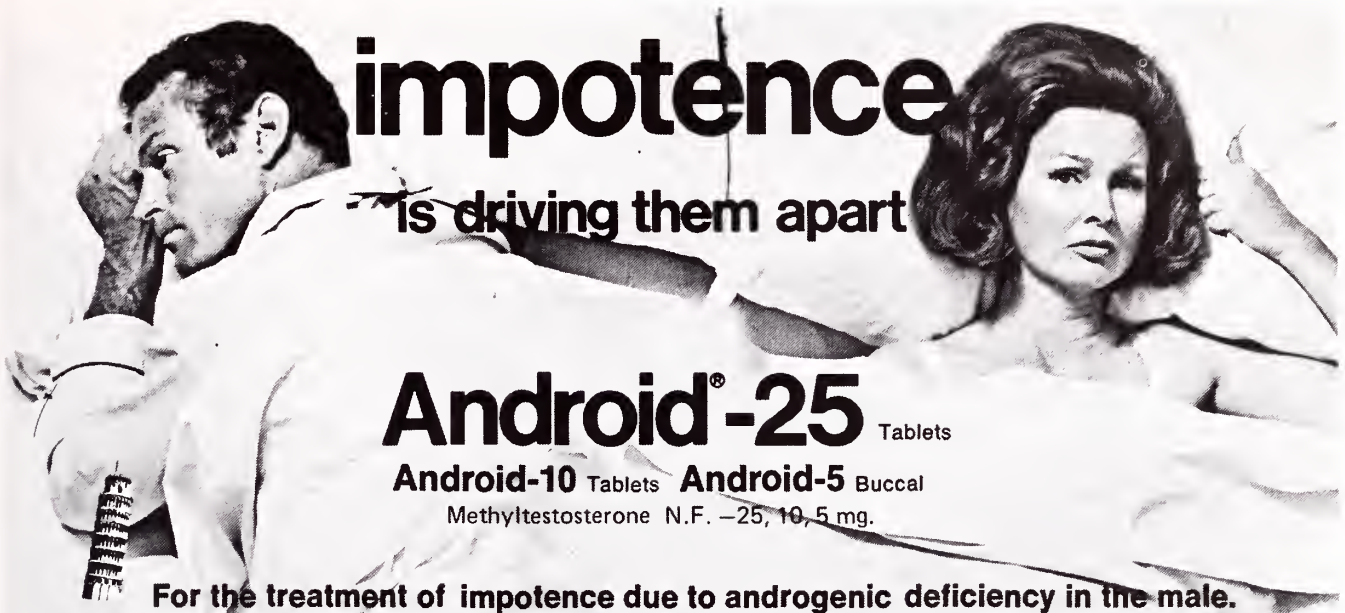

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Beating the Deadline

By Herbert A. Auer, Executive Editor

Now that Cadillac has its own orthopedic surgeon, **Harvey M. Andre, MD,** has been able to stop his weekly trips from Grand Rapids to Cadillac's Mercy Hospital to diagnose orthopedic problems and to do necessary surgery. He began making the weekly trips in 1948, 25 years ago. Members of the MSMS House of Delegates know Doctor Andre as the delegate from Kent County Medical Society who always closes the official meeting of the House with a humorous resolution summarizing the session.

Marjorie Peebles Meyers, MD, Detroit, was the only woman doctor to serve on a reference committee at the winter AMA House of Delegates meeting. Once again Michigan was well represented on committees. Others on busy reference committees were Vernon V. Bass, MD, Otto K. Engelke, MD, and Robert E. Rice, MD.

Robert Young long has been a popular figure in the movie and television industry, but the Committee for National Health Insurance views him as a tool of the AMA. Max Fine, executive director of the Woodcock committee, recently fired off a letter to the president of the American Broadcasting Company asking for equal time to answer "the conservative medical propaganda on the Welby show." Fine alleges that Marcus Welby, MD, as portrayed by Young "is aiding and abetting organized medicine's fight in Washington . . . against reform in the health care system."

Garfield Tourney, MD, chairman of the Wayne State University medical school psychiatry department, in a recent address to WSU medical students cited many cases in which chronic diseases like cancer and stroke bring about significant emotional changes in mentally healthy people. He urged the future doctors to know their patients better.

The development of a comprehensive master plan for the growth of the Muskegon Community College is being directed by **Robert J. Fles, MD,** who serves as chairman of the college board of trustees.

The Transplantation Society of Michigan has been instrumental in bringing about a 200 per cent increase in the number of kidneys transplanted from unrelated donors in the past 16 months, according to **Edward Coppola, MD,** president of TSM. The society uses a specially equipped van to rush donor kidneys to hospitals where patients with matching tissue are awaiting transplant surgery. Doctor Coppola is head of surgery at the Michigan State University College of Human Medicine.

A number of Michigan hospitals responded to a MSMS letter to administrators requesting their help in a smoking-health effort. **Edward J. Klopp, MD,** of Battle Creek, chairman of the MSMS Committee on Public and Environmental Health, reports that replies indicate some gift shops have been instructed not to sell cigarets, that smoking by employes has been forbidden in some hospitals and that no-smoking signs have been posted in patient rooms in some institutions.

An educational campaign to build bipartisan support for construction of a new, 120-bed skilled care facility in Oakland County has been started by **Joseph R. Montante, MD,** of Orchard Lake. Doctor Montante is a member of the Oakland County Board of Commissioners and chairman of the board's health committee.

Dr. Andre

Dr. Meyers

Dr. Montante

Dr. Fles

Young

Must vasodilators and therapy for other diseases come into conflict?

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1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

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Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

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The cover photo, by Craig Porter, takes note of the 13th annual Michigan Conference on Maternal and Perinatal Health, March 27 and 28 in Grand Rapids. See Page 126 for details of the conference program.

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Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. In editorials, the views expressed are those of the writer and not necessarily official positions of the society.

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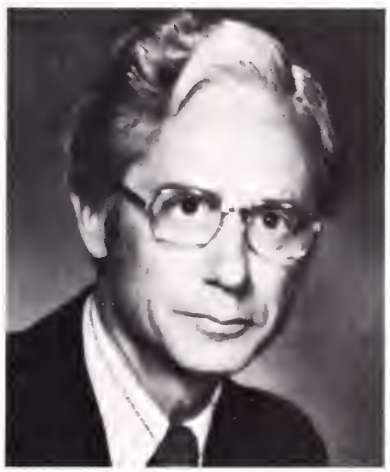
President's Page



Doctor Masters

Consumerism, 1974 . . . .

As one surveys the passing scene today, a common denominator for knowing the answers is the new term, consumerism. I believe Ralph Nader is considered the originator of this popular concept, but is he? In many different ways the unrepresented consumer for years has been demanding a voice in how services are rendered in several fields. One might mention the New England town meeting as a form of local government. The people have wanted a voice in the education of their children, hence the public school boards. In the 1920s and 30s, people felt that banks were not responsive to their needs and the credit union movement was born. There are others.

The point is that it is not unusual for the consumer to want a voice in how the services he needs are delivered. And, now that health care has become a right of every individual the day he or she is born, it occurs to me that consumerism has now come to our medical profession. For years it has been slowly insidious; of late it seems to be a rising torrent. I think this explains PSRO, the insurance commissioner, Medicaid and many other of the increasing perplexities of your practice.

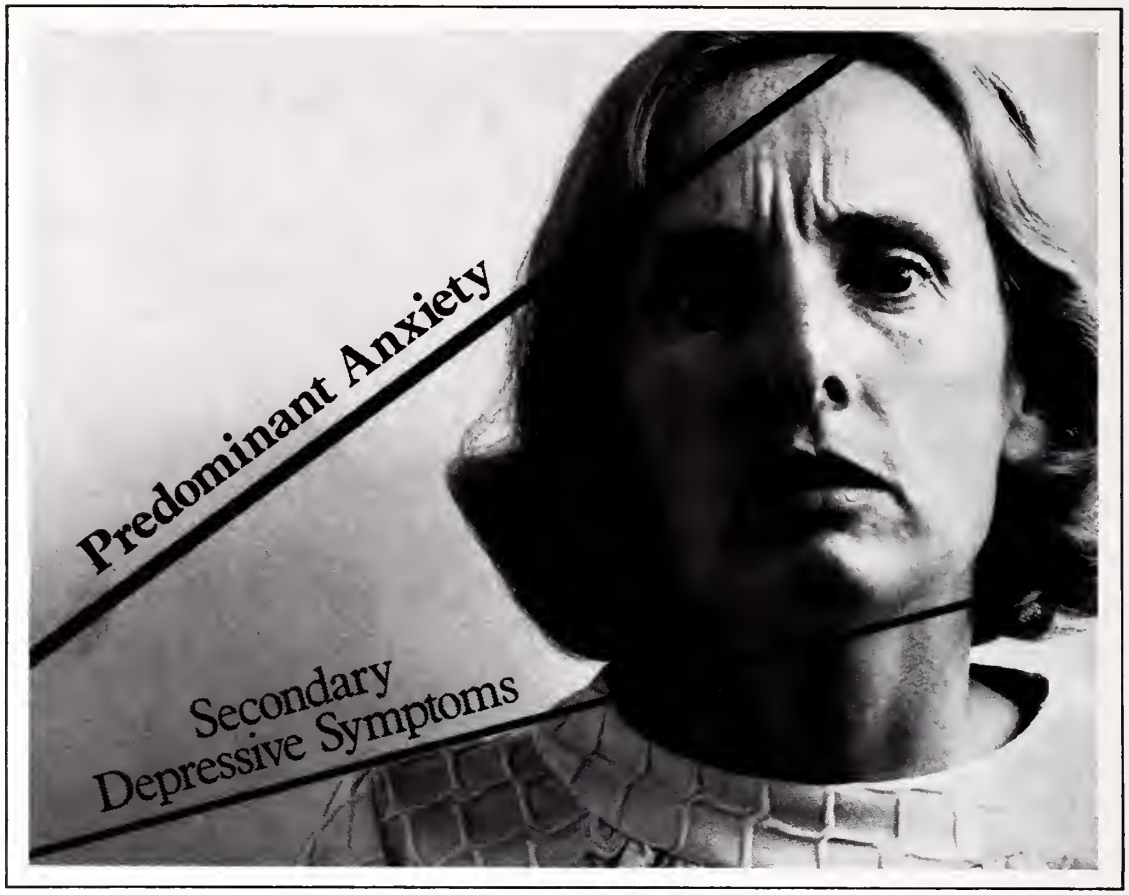
It is high time for organized medicine to recognize this trend and develop better plans for living with it and using its tremendous force to improve health care delivery for all in the future.

In other words, I am saying that we should capitalize on the consumerism movement to reach our goals of improved medical care more universally available at reasonable cost. I hope you do not ask, "Why?"; for if you do, I must respond that there are serious gaps in medical care across our land; there is mal-distribution of physicians; financial cost is a serious problem, particularly in the catastrophic area; it is a sellers' market in medical service today, and physicians are human beings, so there are abuses.

Besides, don't we really need and want the consuming public to be on our side? We just cannot stand aloof and say, as William H. Vanderbilt once said, "The public be damned!" The public is much more sophisticated today. People know we are human and not God. Perhaps it is high time we got together.

I wish your county medical society might consider the possibility of consumer involvement in your daily business. For example, your society might put your hospital administrator on its executive committee. After all, he is a partner in your daily activities and he is an interested person. Your local newspaper editor might fill the same position. Might you consider a banker or a lawyer or a pharmacist on the medical staff of your hospital? Might they not contribute to medical decisions that would benefit your community? What would happen if we had one lay member on every county medical society board in the United States? Well, we might have 3,000 advocates for our position instead of the chorus of dissent we know today!

(Continued on Page 153)



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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

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Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Physicians, Nurses, Students Will Study Maternal, Perinatal Health Problems

More than 700 physicians, nurses and students are expected to attend the 13th Annual Michigan Conference on Maternal and Perinatal Health March 27 and 28 in the Civic Auditorium and Pantlind Hotel in Grand Rapids.

Lloyd A. Kammeraad, MD, of Grand Rapids, conference chairman, and Kenneth J. Vander Kolk, MD, also of Grand Rapids, vice chairman, and their committee have completed all plans for the event.

Among the out-of-state participants will be Howard J. Osofsky, MD, of Philadelphia, director of obstetrics at Temple University; Richard H. Aubry, MD, of Syracuse, N.Y., perinatal center director, Upstate Medical Center, State University of New York, and Thomas K. Oliver, Jr., MD, of Pittsburgh, chairman, department of pediatrics, University of Pittsburgh School of Medicine.

Speakers from the University of Michigan Medical Center include Bruce A. Work, Jr., MD, director, obstetric intensive care unit; Jan Schneider, MD, chief, obstetric service, and Bruce C. Doust, MD, assistant professor, department of radiology.

MSU Participants

Participants from the College of Human Medicine, Michigan State University, East Lansing, include Gerald B. Holzman, MD, associate professor of obstetrics-gynecology and reproductive biology, and Norbert Enzer, MD, chairman, department of psychiatry.

William C. Stewart, MD, director of the regional neonatal program at Bronson Hospital, Kalamazoo, and Mary J. Kokosky, MD, assistant director of pediatrics for the Metropolitan Northwest Detroit Hospital Association, round out the physician speakers while Esther Adkins, RN, Kalamazoo, department of obstetrics, Bronson Hospital will be featured speaker for the session on "The Nurse's Role in Fetal Monitoring."

Speaker for a candlelight dinner Wednesday will be the Rt. Rev. Msgr. Michael Beahan, pastor of St. Mary's Church, Grand Rapids and host for a weekly television program.

A pre-conference program arranged by the Nurses Association of the American College of Obstetricians and Gynecologists, Michigan Section, District V, will open the program Wednesday morning.

Two topics to be discussed during this session include "The Nurse as an Agent of Crisis Intervention" with Elizabeth Seagull, Ph.D., department of human development, MSU College of Human Medicine, and "Psycho-Social Aspects of High Risk Pregnancy" offered by Marilyn L. Poland, RN, BS, MS, instructor, Wayne State University School of Medicine and College of Nursing.

High Risk Pregnancy

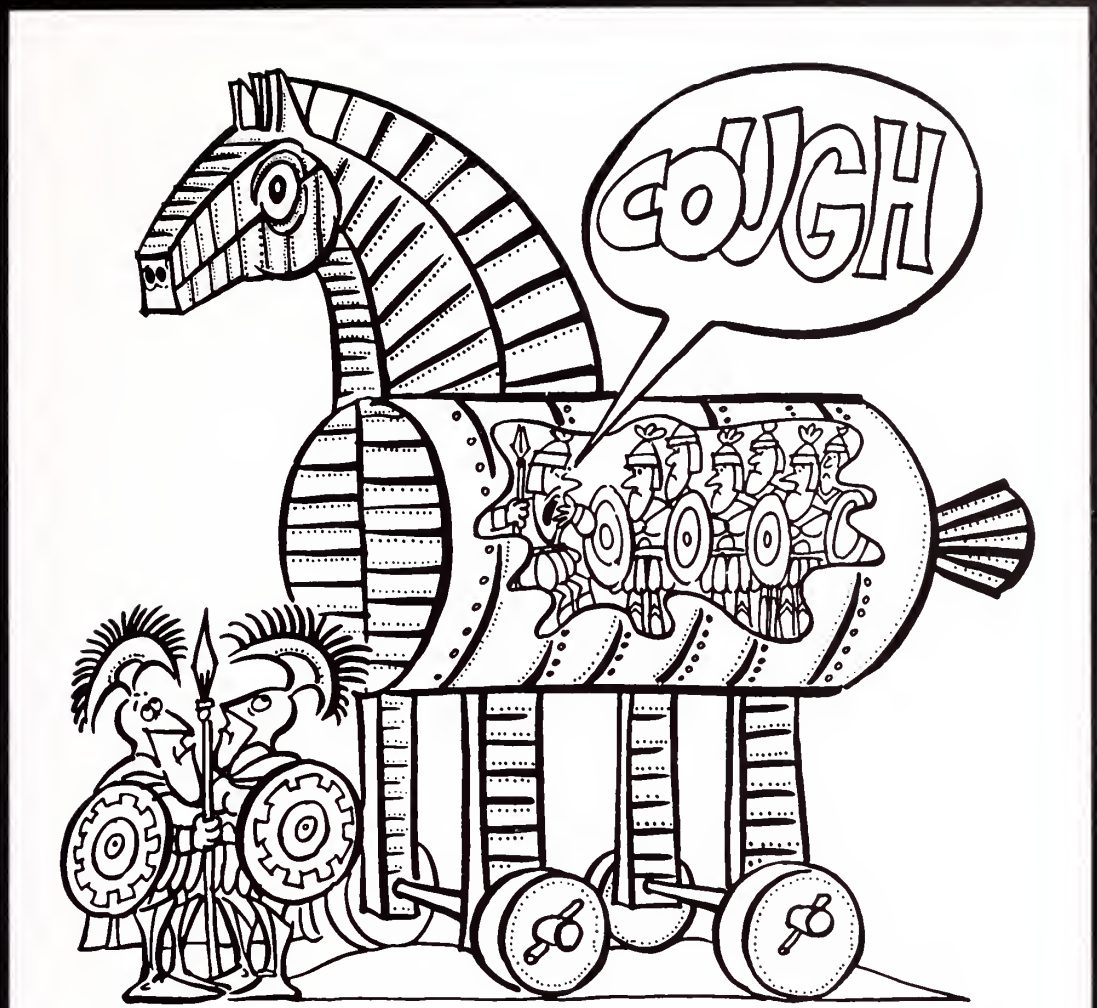
Wednesday afternoon's session will cover "Epidemiology of Perinatal Loss" and will include presentations on socio-economic, medical and nutritional factors involved in the high risk pregnancy.

The afternoon session also will cover topics related to "Plan of Management" including antepartum evaluation, ultra sound in evaluation of fetal growth and fetal growth retardation.

The third session, scheduled for Thursday morning, will feature the "Team Approach to Labor and Delivery" including detection of fetal distress, the nurses' role, effects of analgesia and anesthesia and predictors of neonatal development.

The fourth and final session Thursday morning will center on "The Team Approach to Neonatal Problems" and will include brief presentations on special problems of the newborn and care of the high risk family, ending with "Is It Worth It? — A Critical Question."

There are no conference registration fees but advance registration is suggested and requested by the Michigan State Medical Society Committee on Maternal and Perinatal Health which is responsible for planning and sponsoring the conference. Complete program information and registration blanks may be obtained from Doctor Kammeraad or from Miss Helen Schulte at MSMS Headquarters, East Lansing.



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MSMS Action

Council to Seek PSRO Repeal Through AMA

Here are brief summaries of action by the MSMS Council at its Jan. 30 meeting.

MSMS Council Chairman Robert M. Leitch, MD reported that the Council voted to accept the recommendation of the MSMS Committee on Governmental Medical Care Programs that:

1. MSMS direct its efforts to achieve repeal of PSRO through the AMA and that MSMS provide its full assistance and cooperation to the AMA toward that end.

2. That MSMS move vigorously to implement alternatives to PSRO cited both in MSMS and AMA resolutions in 1973 in order to present a positive argument against government imposed professional standards review.

Also, the Council adopted a recommendation to:

1. Begin now inviting county medical society presidents to regional informational meetings on peer review developments.

2. Urge county medical societies to improve their local peer review processes.

3. Authorize MSMS to apply for HEW designation as Management Resource Center to serve county medical societies that request help and service re peer review or PSRO.

Upon the recommendations of the MSMS Legal Affairs Committee and the Council's Legislative Policy Committee, the Council took stands on three issues before the Michigan legislature.

The Council voted to endorse the licensure of out-patient ambulatory surgical centers as required by SB 888 provided four modifications are made. Support was approved for HB 5816 to provide for the certification of advanced emergency medical technicians provided three changes are made. The Council voted that MSMS will support fiscal control of HMOs through regulation by the State Insurance Commissioner and that MSMS should reiterate its concerns for medical controls of HMOs with the notations offered by the Legal Affairs Committee. The Council voted to continue to oppose generic substitution without quality constraints and that MSMS offer an amendment that would provide a preprinted statement on prescription pads: "Another brand of generically equivalent product, identical in dosage, form and content of active ingredient(s) may be dispensed UNLESS checked."

The Council voted to write to the HEW Secretary opposing his proposal for preadmission certification of government patients for hospitalization and authorized the MSMS legal counsel to enter the possible AMA law suit if HEW proceeds with its plans. *(The secretary later said he would not pursue the proposal.)*

Several appointments were made by Chairman Leitch: Donald R. McCorvie, MD, of Williamston, delegate to the Michigan Health Council: Robert E. Rice, MD, of Greenville, alternate, and Robert C. Prophater, MD, of Bay City, the Council representative on the MDPAC board.

Progress in the formation of the new MSMS-State Bar of Michigan Liaison Committee was reported to the Council. Three joint task forces are to be appointed to consider professional liability, availability of medical records and interprofessional relations.

The Council voted to commend the AMA for its new attempts to encourage component societies to recruit more members by rebating one-half of the first year's dues. The Council also voted to accept incentive monies from the AMA for quick relay by MSMS of AMA dues payments and to put such funds in the MSMS creative reserve funds for use in member benefit programs.

Upon the request of the Michigan Academy of Family Physicians, the MSMS Council agreed to call to the attention of Michigan Medical Service the definition of a specialist adopted by the MSMS House of Delegates in 1971. MAFP reports that MMS is using the definition adopted by the House in 1966 rather than the new version. This matter relates to payments made by MMS to specialists and generalists.

Council members reviewed the success of the new MSMS-Medicaid Liaison Committee in handling complaints from members and moved to establish a similar MSMS committee to handle complaints from members about Blue Shield and Blue Cross. MSMS members will be asked through *Medigram* to mail in their complaints and questions.

C. Allen Payne, MD, Grand Rapids, was re-elected to a two-year term on the MSMS Board of

(Continued on Page 143)

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Brief Summary

Indications—Placidyl (ethchlorvynol) is indicated as short-term hypnotic therapy in the management of insomnia.

Contraindications—Drug hypersensitivity and porphyria.

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Precautions—Toxic amblyopia has been reported with long-term continuous use of ethchlorvynol. Permanent visual defects have been observed, although amblyopia has improved after discontinuation of the drug. Drug dosage should be limited for elderly and debilitated patients to the smallest effective amount. If pain is present, this drug should only be given if insomnia persists after pain is controlled with analgesics. Caution is advised in prescribing the drug for patients who are being treated with either MAO inhibitors or antidepressants. Transient delirium has been reported with the combination of Placidyl and amitryptyline. Drug dosage should be reduced if prescribed for patients receiving MAO inhibitors or antidepressants. Caution should be exercised in patients with impaired hepatic or renal function. Patients who respond unpredictably to barbiturates or alcohol, or who exhibit excitement and release of inhibition in association with such agents, may also react in this way to Placidyl. Rarely, patients may exhibit symptoms suggestive of an unusual susceptibility to the drug; such as prolonged hypnosis, profound muscular weakness, excitement, hysteria, or syncope without marked hypotension. Transient giddiness or ataxia may occur.

Adverse Reactions—Hypotension, nausea or vomiting, gastric upset, aftertaste, blurring of vision, dizziness, facial numbness, and allergic reaction typified by urticaria have been reported following Placidyl administration. Mild "hangover" and symptoms of mild excitation have occurred in some patients. There have been rare reports of cholestatic jaundice occurring in patients taking ethchlorvynol. A few cases of thrombocytopenia have been reported in patients receiving ethchlorvynol. 304431

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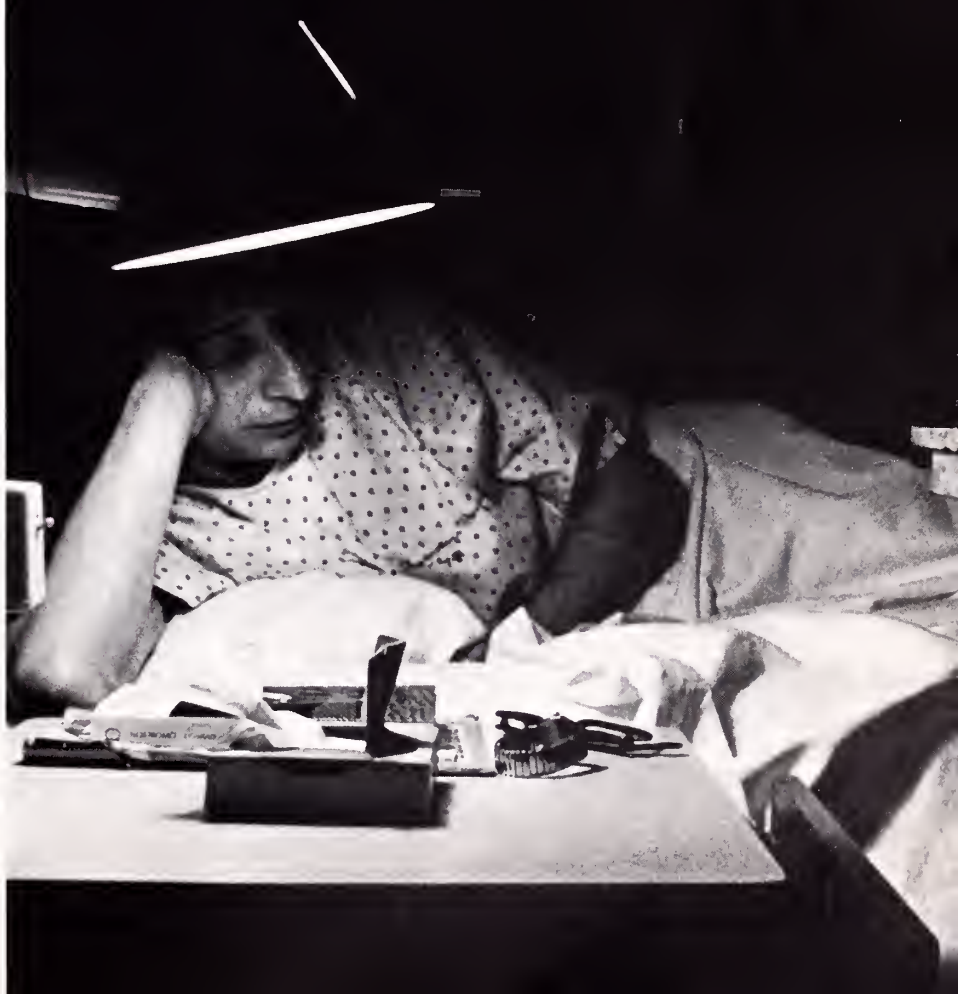

The Weight of Professional Opinion

It's time for action to defend the laws and regulations that protect your patients against drug substitution.

These professional and trade organizations are united in supporting antisubstitution statutes and regulations:

The American Academy of Dermatology

The Board of Directors of the American Academy of Family Physicians

The Executive Board of the American Academy of Neurology

The Committee on Drugs of the American Academy of Pediatrics

The American College of Allergists

The Executive Committee of the American College of Obstetricians and Gynecologists

The Board of Regents of the American College of Physicians

The Board of Trustees of the American Dental Association

The Board of Trustees of the American Medical Association

The American Psychiatric Association

The Executive Committee of the National Association of Retail Druggists

The Board of Directors of the Pharmaceutical Manufacturers Association

The National Wholesale Druggists' Association

Joint Statement on Antisubstitution Laws and Regulations

The purpose of this statement is to affirm the support of the participating organizations for the laws, regulations and professional traditions which prohibit the unauthorized substitution of drug products.

Traditionally, physicians, dentists and pharmacists have worked cooperatively to serve the best interests of patients. Productive cooperation has been achieved through mutual respect as well as a common concern for the ideals of public service. This mutual respect has been reflected, in part, by joint support over the years for the adoption and enforcement of laws and regulations specifically prohibiting unauthorized substitution and encouraging joint discussion and selection of the source of supply of drug products. The basic principles of medical, dental and pharmacy practice are thus utilized and preserved in the interest of patient welfare.

The antisubstitution laws have not obstructed enhancement of the professional status of pharmacy any more than they have in and of themselves guaranteed absolute protection from unsafe drugs, or freed physicians, dentists and pharmacists from their responsibilities to patients. As a practical matter, however, such laws and regulations encourage interprofessional communications regarding drug product selection and assure each profession the opportunity to exercise fully its expertise in drug usage, to the advantage of patients.

Physicians and dentists should be urged to increase the frequency and regularity of their contacts with pharmacists in selection of quality drug products, recognizing that economies to patients can be improved through such communication, taking into account the patients' needs. The pharmacist's knowledge of the chemical characteristics of drugs, their mode of action, toxic properties and other characteristics that assist in making drug selection decisions should be utilized to the fullest extent practicable by physicians and dentists in serving their patients.

Since drug product selection entails knowledge derived from clinical experience, the physician's and dentist's roles in product selection remain primary and do not permit delegation of decisions requiring medical and dental judgments. A broader role in therapy will evolve for pharmacists as improved understanding and cooperation among the professions continue to grow.

There has been no evidence that there are convincing reasons to modify or repeal existing laws and regulations prohibiting the unauthorized substitution of another drug product for the one specified by a prescriber. It is our belief that such laws and regulations merit the joint support of the medical, dental and pharmaceutical professions and the pharmaceutical industry.

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Amniotic Fluid Bilirubin Quantitation in the Management of the Rh Sensitized Female

By Carl P. Brandt, MD; Donald G. Young, MD, and Kenneth J. Vander Kolk, MD, FACOG, Grand Rapids

Introduction

Prediction of the presence of hemolytic disease of the newborn has greatly enhanced fetal salvage in this condition. In 1939 Levine proposed that the Rh problem reflected maternal immunization to a blood group antigen. The value of amniotic fluid examination was first reported by Bevis in 1950.[1,2] He later demonstrated that the concentration of bilirubin in amniotic fluid correlated with the severity of erythroblastosis fetalis.[3] Liley later described a prospective program of management for the Rh sensitized female.[4] His work confirmed the value of using the absorbance of amniotic fluid at 450nM as a means of predicting the extent of fetal red blood cell hemolysis. Using a scanning spectrophotometer an absorbance curve of amniotic fluid is obtained from 365 to 550nM. The absorbance at 450nM is calculated applying an Allen correction and interpreted relative to the gestational age of the fetus.

Many attempts have been made to improve the reliability of amniotic fluid analysis but success has been limited.[5,6,7] Quantitation of bilirubin has proven in the past tedious and often incomplete. A simplified method utilizing chloroform extraction[8] was evaluated at Butterworth Hospital, Grand Rapids. This report evaluates this new method and correlates its clinical usefulness with the Liley method.

This paper was presented originally at the Western Michigan Research Day in May, 1973. The authors wish to express appreciation to Miss Amanda Stressman for technical preparation of this paper.

Materials and Methods

Forty-nine amniotic fluid specimens obtained from 18 patients in our Rh Clinic were studied. An absorption curve of each specimen was obtained and the absorbance at 450nM was determined by the method of Liley. A correction for oxyhemoglobin equivalent to 5 per cent of the 415nM peak was subtracted from each 450nM absorbance. The corrected absorbances were plotted on a Liley diagram against the gestational age for each patient to determine the degree of involvement.

On each fluid an aliquot was assayed for total bilirubin content by the method of Mallikarjuneswara.[8] The method involves a single extraction with a chloroform analine mixture. A fourfold concentration of the bilirubin is obtained. The bilirubin concentration is determined at 453nM. The method is standardized using standard bilirubin in chloroform. The results are calculated in milligrams per dl. of amniotic fluid.

A statistical comparison of the data on each fluid obtained by Liley's method and by the chloroform analine extraction technique was carried out.

Discrepancies in the predictive capability of each technique were determined and their potential effect on the clinical management studied.

(Continued)

Scientific Articles

Results

Figure 1 is a plot of the values by the two techniques on the forty-nine amniotic fluid specimens. The calculated regression line is:

Y = 0.0055 + 1.027X where
Y is the corrected absorbance at 450 by the Lilly technique and
X is the bilirubin in milligrams per dl.

The standard error of estimate was 0.022. The coefficient of correlation between the two parameters was 0.95 indicating a close agreement between the two techniques.

When the 450 absorbance is calculated from the bilirubin level using the above equation it can be plotted on a Liley diagram against gestational age. Forty-four (89 per cent) of the 49 specimens yielded the same calculated class as that determined spectrophotometrically. Of the five cases in which a discrepancy occurred *(circled in Figure 1)* there was only one class difference, four being one class higher and one, one class lower than spectrophotometrically determined absorbances at 450nM. In general, these discrepancies represented a small change from the upper limits of one class to the lower limits of another.

Discussion

The examination of amniotic fluid utilizing Liley's method of spectrometric analysis is the standard by which any new method must be compared. There are three conditions, however, where accurate absorbance readings cannot be obtained. These include amniotic fluid contaminated with blood, meconium, or cloudy fluid due to excessive vernix or squamous epithelial cells. Following a "bloody tap" one must wait one or two weeks for clearing of the fluid before another scan can be performed. Oxyhemoglobin, the breakdown product of red blood cells in amniotic fluid, absorbs at 415nM and also produces a false increase in the bilirubin absorption at 450nM. Small quantities of oxyhemoglobin can be corrected for by the subtraction of 5 per cent of the 415nM absorbance from the 450nM absorbance. However, larger amounts of oxyhemoglobin cannot be adequately corrected for rendering the interpretation of Liley's method invalid. Figure 2 represents a normal spectrometric scan and a second specimen contaminated with oxyhemoglobin reflected in the large absorbance at 415nM. Cloudy amniotic fluid and meconium staining alter the 450nM absorbance due to high background absorption. In these three conditions the obstetrician is frustrated in his attempts to manage these high risk pregnancies.

An alternative is the quantitative extraction of bilirubin by the technique described. The method extracts more than 99 per cent of the bilirubin and is sensitive to 0.00125mg. dl. of bilirubin in amniotic fluid. The test takes approximately 30 minutes to complete and does not require a scanning spectrophotometer making it accessible to smaller laboratories. Most important, however, is that the presence of blood, meconium or vernix did not interfere with the quantitative extraction of bilirubin.

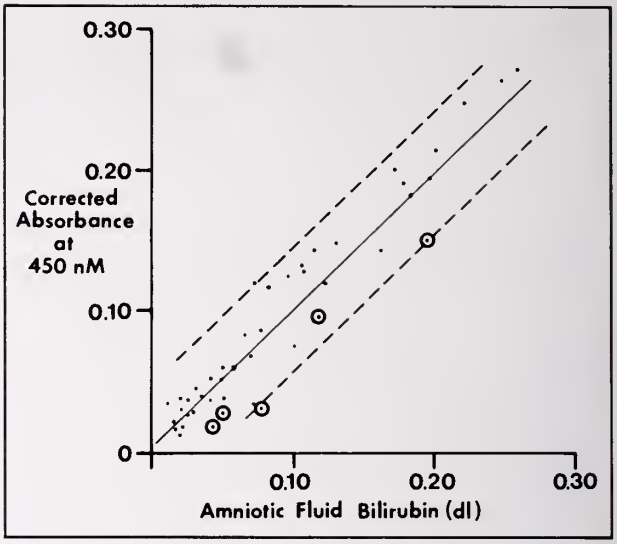

Figure 1. Forty-nine amniotic fluid specimens as calculated by the two techniques. The coefficient of correlation = 0.95.

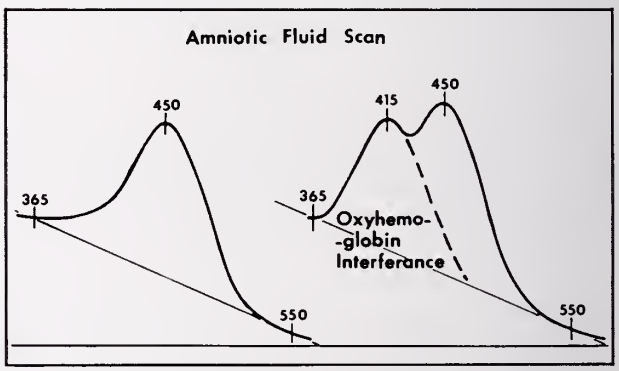

Figure 2. Two amniotic fluid scans. An uncontaminated specimen on the left and a second specimen containing oxyhemoglobin reflected in the absorption at 415nM.

This back up system for evaluation of the Rh sensitized female has proven useful in several cases since being made available in our laboratory. An illustration is a Gravida IV, Para II, AB I white female whose first pregnancy was uneventful. Her second pregnancy resulted in a miscarriage at three months. Her third child required three exchange transfusions due to maternal sensitization to Rh_0 antigen. Her fourth pregnancy was uneventful until 28 weeks gestation when amniocentesis

(Continued on Page 136)

Perinatal Tips

By Paul M. Zavell, MD, Detroit

The following case from the files of the Wayne County Medical Society Perinatal Mortality Study Committee is presented as an aid in continuing education.

Maternal

Almost nothing is known of this 21-year-old black mother. We know she has two children living and said to be well at home and that she had at least one spontaneous abortion. She had received no prenatal care and presented herself in advance labor in the emergency room of a hospital where she quickly delivered a daughter. At delivery it was noted that the placenta was 80 per cent calcified.

Fetal

This 6 lb. 11 oz. black female had an Apgar of 9 at 1 minute and 10 at 5 minutes. She seemed to do well in the newborn period without complications of any kind until the fourth day of life when she developed a temperature of 38°C and vomited several successive feedings. A physical exam was completely normal. As a precautionary measure a blood culture was drawn and the infant was started on antibiotics (penicillin and Kantrex). For the next two days the infant continued to run a temperature of 38°C but the blood cultures were reported as negative. An L.P. was done that was traumatic but a culture was done (subsequently reported as negative) with protein of 118 and sugar of 65. Blood sugars were done on two occasions between the fourth and sixth days and found to be 40 and 90 mgm% respectively. On day seven the temperature returned to normal and the infant was noted to be feeding well. Twenty-four hours later, however, vomiting began anew and some loose stools were noted. Chest x-ray was done and found to be normal. A flat plate of the abdomen showed the distal colon to be dilated with an abrupt termination of this dilation at mid-sigmoid and only a small amount of gas in the rectum. To rule out colonic obstruction a barium enema was done but this was normal. At the same time occasional clonic-tonic movements of the extremities intermixed with fine tremors were first noted, sneezing began, frequent loose stools with some vomiting started and a high-pitched cry was noted.

In discussing the status of the child with the parents, the father then admitted he was taking methadone, 10 mgm/day. However the mother denied any drugs, specifically methadone or heroin. For diagnosis, urines were obtained from both parents (both were subsequently positive for methadone). The infant was started on Thorazine 1 mgm/Kilo. q 6 hr. Dramatic results with disappearance of all symptoms resulted very quickly. After two weeks of Thorazine treatment an attempt to wean the patient from medication during the third week was abandoned because of recurrence of vomiting and diarrhea. Finally after a total of almost five weeks the infant was weaned successfully from Thorazine.

The infant was discharged to the parents through court action after child abuse forms were filed with the Children's Services for appropriate investigation; and supervision of home life was assured by the Child Protective Agency. The parents had now joined a drug treatment program. On one follow-up visit shortly thereafter the infant appeared normal and appeared to be progressing satisfactorily.

(Continued)

Doctor Zavell is a member of the Neo-Natal and Hospital Care Committee, Michigan Chapter, American Academy of Pediatrics, and chairman of the Perinatal Mortality Study Committee, Wayne County Medical Society.

Perinatal Committee Comments

1. Sneezing, fine tremors, vomiting, a high pitched cry are not normal for a newborn. They should alert one to possible addiction or CNS problem.
2. Tremors in an infant should be investigated by obtaining blood sugar, calcium and phosphorous and where indicated by an L.P. These tests should help to determine if hypoglycemia, tetany of the newborn or CNS disease or condition exist.
3. It is a good idea (if possible) to routinely collect and study the urine of mothers with little or no prenatal care for the presence of barbiturates, codeine, demerol, quinine, etc., so as to be alerted to possible drug problems in the infant early. Because of the cost involved, perhaps storage of the mother's urine for the period the infant is in the hospital (rather than immediately performing these tests) while observing the infant for any suspicious symptoms could be done. If no symptoms develop, the urine could be then discarded.
4. Because some infants do not develop significant narcotic withdrawal symptoms until the fourth, fifth, (or as in this case, the eighth) day, early discharge of infants on the third day of life may at times be fraught with some danger to the infant. Indeed an occasional early sudden death syndrome may be due to undetected untreated narcotic withdrawal in an infant.
5. Study of the infant's urine when the infant shows narcotic withdrawal symptoms is of no value since by the time symptoms appear in the infant drug levels in the urine are either non-existent or too low to detect.
6. A pregnant woman who is too agitated in labor or fails to receive relief with larger than usual doses of demerol should be suspect as a possible narcotic user.
7. As this case clearly shows narcotic addicted infants may need to be treated for a prolonged period of time. Indeed some experience now obtained seems to show that methadone addicted infants need closer and longer supervision than many heroin addicted infants.
8. The committee has no knowledge yet as to the effect the use of cough medicines with codeine may have at a later age on children who were narcotic addicted at birth. Since knowledge is very sparse it seems wise to avoid such preparations in such children for the present.

was performed resulting in a bloody tap. The spectrometric data was unreliable due to the large absorbance at 415nM. Total bilirubin determinations were performed on the fluid revealing a low Class I reading. Repeat amniocentesis resulted in bloody fluid but she remained in Class I by total bilirubin method. At 39 weeks a repeat Cesarean section resulted in an unaffected O negative male infant.

Total bilirubin assay of amniotic fluid in our hands has proven to be a reliable technique for the prediction of hemolytic disease. The added benefits of reliable data on blood, meconium or vernix contaminated fluids, expand the usefulness of amniotic fluid assay. The method's simplicity makes it adaptable for performance in smaller laboratories.

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BIOTRANSFORMATION OF ANESTHETICS: *Clinical Implications*

Part II

By Gianfranco Dal Santo, MD, Detroit

As mentioned in Part I, fluoride, chloride, trifluoracetic acid and trifluoracetyl ethanolamine are biotransformation products of **halothane** *(Figure 1).*[1] At this moment, however, there is no direct evidence that these metabolites cause significant toxicity after halothane administration in humans. Consequently, the often mentioned "liver toxicity" of halothane cannot be caused by a "normal" metabolite of halothane. If it were, such toxicity would have reached epidemic proportions.[2]

Open, however, is the question of whether biotransformation of halothane in humans might produce, in certain instances, intermediate metabolites that could act as *haptens*[3] and cause hepatotoxicity or which might "sensitize" the patient to its successive administration.[5] Convincing clinical evidence on these points is not yet available. In particular, repeated halothane anesthetics are not invariably followed by liver disfunction. Instead, it seems more likely that family or individual predisposition, as well as "professional" exposure[4] could better explain the rarity of this mechanism.

Finally, the relatively new concept of **enzyme induction** should be considered. In enzyme induction certain drugs *(i.e., barbiturates)* are able to accelerate enzymatic activity, thereby increasing the biotransformation of other drugs,[5] including inhalation anesthetics. At this moment, however, there is no report available that such induction causes an increase in the incidence of postoperative liver dysfunction. It is also remarkable that halothane itself can cause enzyme induction and, as a consequence, affect its own biotransformation as well as hepatic metabolism.[6]

In the light of these findings about biotransformation of halothane, it does not seem, at this moment, that substantial changes in the administration of this agent are indicated. Of course, its indiscriminate and uncontrolled use must be avoided.

It has been known for a long time that **intravenous anesthetics** *(thyobarbiturates, methohexital, neurolept-analgesics, ketamine, etc.)* are biotransformed; also, that biotransformation plays quite an important role in the **duration** of their anesthetic effects. This is in contrast with the case of the inhalation anesthetics in which biotransformation seems not to affect their length of action. Apparently, no toxic reactions from the metabolites of intravenous anesthetics, when administered under average anesthetic doses, have yet been reported.

Local anesthetics, too, are biotransformed. Although biotransformation plays little or no role in the temporal course of local anesthesia, it generates metabolites which may be the cause of systemic toxic effects.

Contrary to what occurs with general anesthetics, **non-depolarizing muscle-relaxants** *(d-tubucurarine, gallamine and pancuronium)* are eliminated unchanged in the urine. In this case, *rapid distribution* substitutes for biotransformation as well as for urinary elimination and therefore conditions duration of the muscle-paralyzing effect. It is reasonable to expect then, that any cause which affects this rapid distribution can prolong muscular relaxation.

(Continued)

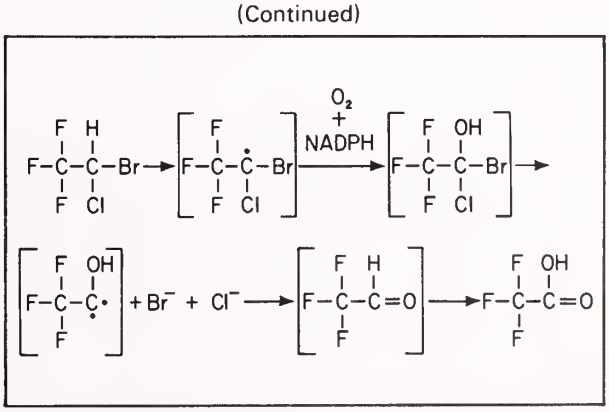

Figure 1. Biotransformation of halothane.

The importance of rapid distribution of muscle-relaxants has been clearly demonstrated[7-10] employing radiolabeled d-tubocurarine. Subsequent to intravenous administration, a single dose of ^{14}C-labeled d-tubocurarine rapidly disappears from plasma. At the same time, however, the urinary elimination appears quite slow *(Figure 2),* the maximal cumulative elimination *(80 percent of the administered dose)* being reached at the seventh hour after injection. The passage of the drug into the extravascular compartment is immediate and very rapid. From *Figure 2* it can be seen that the steeply ascending component of the passage curve coincides with the rapidly descending phase of the curve of disappearance of d-tubocurarine from plasma. Now, as the duration of the muscle-paralyzing effect of a single IV dose of dimethyl-d-tubocurarine lasts an average of 30 minutes, it is apparent that the relaxant effect of the drug coincides with its rapid passage into the extravascular compartment, i.e., with a rapid distribution process; while urinary elimination is of limited significance. Later on, however, when the muscle-paralyzing effect is dissipated, urinary excretion increases steadily, playing a fundamental role in the elimination of d-tubocurarine. It has been demonstrated[10,11] that renal insufficiency does not significantly affect the muscle-relaxant response to a *single* dose of d-tubocurarine.[1] Instead, keeping in mind the above urinary data, it is fair to expect that renal insufficiency may cause prolonged recovery from *subsequent* maintenance doses.

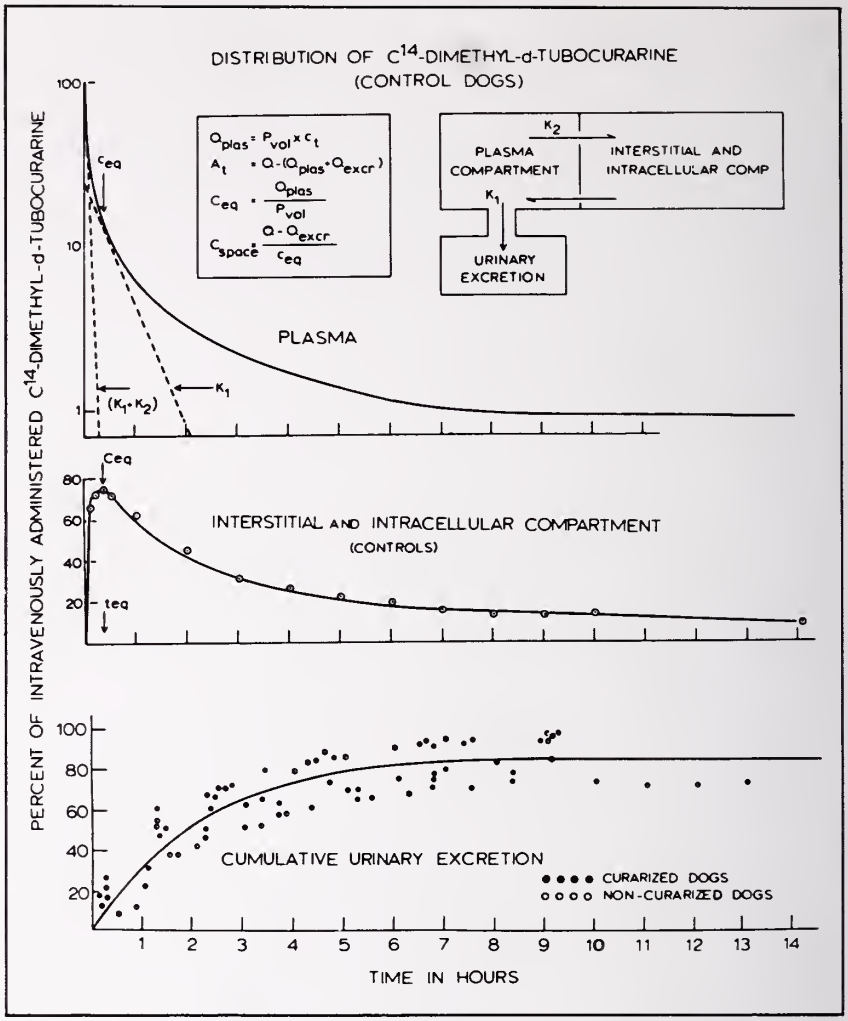

Figure 2. Kinetics of distribution of a trace dose of ^{14}C-dimethyl-d-tubocurarine intravenously administered to control dogs *(from Dal Santo[12]).* For explanation and interpretation, see text.

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(Continued on Page 143)

Presented at the 18th all-day scientific meeting of the Michigan Society of Anesthesiologists, May 5, 1973, Detroit, Mich. The first part of the article appeared in the February issue. Data reported in this article were obtained with the aid of PHS NB 04123 0102, United Health Foundation, Abbott Laboratories and Detroit General Hospital Research Corporation grants.

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PNEUMOCONIOSIS: *A Medical–Legal Classification*

By Victor A. Kelmenson, MD, FCCP, Detroit

Background

The laws of various countries and of various states of the United States vary but it is recognized that where an occupation subjects a worker to unusual hazards any resulting disease should have special compensation.

In the United States this has been recognized nationally by the federal government for coal miners[1] but not for other industries. The necessity for special treatment of coal miners resulted from unrealistic laws in the state of West Virginia. However since once the federal government has entered a field it seldom withdraws, we can expect further legislation to extend the principle of federal compensation to other miners and eventually to most of the occupations that involve exposure to dust — the pneumoconioses.

Previous Classifications

Several classifications of the x-rays of the workers with dust exposure have existed in the past and none of them has been wholly satisfactory. The most commonly used was the International Labor Organization System *(ILO 1958 Geneva Classification).* This was modified by physicians from different countries following a meeting in October, 1957, in Cincinnati.[2] Represented were the United States, West Germany, Canada, the United Kingdom, Finland and the Republic of South Africa. These doctors devised a modification which has been labeled the UICC/Cincinnati Classification. UICC stands for Union Internationale Contre Le Cancer. This has been applied to asbestosis and coal miner's pneumoconiosis but will undoubtedly be extended to include all of the pneumoconioses in the future.

Michigan

Although the UICC/Cincinnati Classification has the support of the National Institute of Occupational Safety and Health of the United States Public Health Service, the American College of Radiology and the American College of Chest Physicians it is not a satisfactory one for the purpose of determining Workmen's Compensation in the state of Michigan.

For one thing it is completely radiologically oriented and in my practice I find many workers who have extensive x-ray changes who have little disability and many who have extensive disability and only slight x-ray changes.[3]

Although the x-rays are an objective method of examination they cannot be used exclusively for classification. For this reason the 1966 KS Classification has proved superior. In Michigan the amount of compensation awarded has been the result of a compromise after negotiations between the attorney for the disabled worker and the attorney for the company (or its insurance carrier. The largest companies are self-insured). Very few of these cases are actually tried before a referee.

This compromise takes into consideration the dust exposure, the length of time the worker has had such exposure and reports from physicians employed by the company and by the employee on a case basis. The law is liberal enough so that an aggravation of a pre-existing condition is grounds for compensation.

Obviously the attorneys must know the amount of disability as well as the x-ray changes in order to come to a fair settlement. For this the personal opinion of a physician who has examined the worker is necessary. The disability cannot be determined by the x-ray appearances alone and that is why the use of the UICC/Cincinnati Classification is only partly valuable.

Also, the actual classification, in use, has too many variables to allow attorneys who are not physicians to decide the amount of settlement. For instance, will a larger settlement be given to a worker with a profusion of 2/3 than one who has a 2/2 *(see Small Opacities in UICC/Cincinnati Classification)?* This is too fine a point for the attorneys.

The 1966 KS Classification for pneumoconioses was designed purely for the purposes of compensa-

The author is medical director of Wehenkel Clinic, Detroit.

(Continued)

UICC/CINCINNATI CLASSIFICATION OF RADIOGRAPHIC APPEARANCES OF PNEUMOCONIOSES

		Codes	Definitions
SMALL OPACITIES	Rounded		
	Profusion		The category of profusion is based on assessment of the concentration of opacities in the affected zones. The standard films define the mid categories.
		0/- 0/0 0/1	Category 0 - small rounded opacities absent or less profuse than in category 1.
		1/0 1/1 1/2	Category 1 - small rounded opacities definitely present but relatively few in number.
		2/1 2/2 2/3	Category 2 - small rounded opacities numerous The normal lung markings are usually still visible.
		3/2 3/3 3/4	Category 3 - small rounded opacities very numerous. The normal lung markings are partly or totally obscured.
	Type	p q r	The nodules are classified according to the approximate diameter of the predominant opacities. p - rounded opacities up to about 1.5mm diameter q - rounded opacities exceeding about 1.5mm and up to about 3mm diameter. r - rounded opacities exceeding about 3mm and up to about 10mm diameter.
	Extent	Lung zones	The zones in which the opacities are seen are recorded. Each lung is divided into thirds - upper, middle, lower zones. Thus a maximum of 6 zones can be affected.
	Irregular		
	Profusion		The category of profusion is based on assessment of the concentration of opacities in the affected zones. The standard films define the mid categories.
		0/- 0/0 0/1	Category 0 - small irregular opacities absent or less profuse than in category 1.
		1/0 1/1 1/2	Category 1 - small irregular opacities definitely present but relatively few in number. The normal lung markings are usually visible.
		2/1 2/2 2/3	Category 2 - small irregular opacities numerous The normal lung markings are usually partly obscured.
		3/2 3/3 3/4	Category 3 - small irregular opacities very numerous The normal lung markings are usually totally obscured.
	Type	s t u	As the opacities are irregular, the dimensions used for rounded opacities cannot be used, but they can be roughly divided into three types s - fine irregular or linear opacities t - medium irregular opacities u - coarse (blotchy) irregular opacities
	Extent	Lung zones	The zones in which the opacities are seen are recorded. Each lung is divided into thirds - upper, middle, lower zones - as for rounded opacities
LARGE OPACITIES	Size	A B C	Category A - an opacity with greatest diameter between 1cm and 5cm, or several such opacities the sum of whose greatest diameters does not exceed 5cm Category B - one or more opacities larger or more numerous than those in category A, whose combined area does not exceed one third of the area of the right lung Category C - one or more large opacities whose combined area exceeds one third of the area of the right lung
	Type	wd id	As well as the letter 'A', 'B' or 'C', the abbreviation 'wd' or 'id' should be used to indicate whether the opacities are well defined or ill defined.
OTHER FEATURES	Pleural thickening		
	Costophrenic angle	Right Left	Obliteration of the costophrenic angle is recorded separately from thickening over other sites. A lower limit standard film is provided.
	Other sites	1 2 3	Grade 0 - not present or less than grade 1. Grade 1 - up to 5mm thick and not exceeding one half of the projection of one lateral chest wall. A lower limit standard film is provided. Grade 2 - more than 5mm thick and up to one half of the projection of one lateral chest wall or up to 5mm thick and exceeding one half of the projection of one lateral chest wall Grade 3 - more than 5mm thick and extending more than one half of the projection of one lateral chest wall
	Diaphragm		
	Ill defined	Right Left	The lower limit is one third of the affected hemidiaphragm A lower limit standard film is provided.
	Cardiac outline		
	Ill defined (shagginess)	1 2 3	Grade 0 - up to one third of the length of the left cardiac border or equivalent. Grade 1 - above one third and up to two thirds of the length of the left cardiac border or equivalent Grade 2 - above two thirds and up to the whole length of the left cardiac border or equivalent. Grade 3 - more than the whole length of the left cardiac border or equivalent.
	Pleural calcification		
	Diaphragm Walls Other sites	1 2 3	Grade 0 - no pleural calcification seen. Grade 1 - one or more areas of pleural calcification, the sum of whose greatest diameters does not exceed 2cm. Grade 2 - one or more areas of pleural calcification, the sum of whose greatest diameters exceeds 2cm but does not exceed 10cm. Grade 3 - one or more areas of pleural calcification, the sum of whose greatest diameters exceeds 10cm.

OTHER SYMBOLS

OBLIGATORY

- ca - suspect cancer of lung or pleura.
- co - abnormality of cardiac size or shape.
- cp - suspect cor pulmonale.
- es - eggshell calcification of hilar or mediastinal lymph nodes.
- tba - opacities suggestive of active clinically significant tuberculosis.
- od - other significant disease. This includes disease not related to dust exposure, e.g. surgical or traumatic damage to chest walls, bronchiectasis, etc.

OPTIONAL

- ax - coalescence of small rounded pneumoconiotic opacities.
- bu - bullae.
- cn - calcification in small parenchymal opacities.
- cv - cavity.
- di - marked distortion of the intra-thoracic organs.
- em - marked emphysema.
- hi - marked enlargement of hilar shadows.
- ho - honeycomb lung.
- k - Kerley (septal) lines.
- px - pneumothorax.
- rl - pneumoconiosis modified by rheumatoid process.
- tb - inactive tuberculosis.

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

FORM APPROVED
BUREAU BUDGET NO. 85 R0138

PUBLIC HEALTH SERVICE
ENVIRONMENTAL HEALTH SERVICE
ENVIRONMENTAL CONTROL ADMINISTRATION
Bureau of Occupational Safety and Health
Federal Coal Mine Health and Safety Act of 1969
Medical X-Ray Examination Program
ROENTGENOGRAPHIC INTERPRETATION

THIS SEQUENCE NUMBER FOR ALFORD USE ONLY

NOTE: Please record your interpretation of a single film by placing an "X" in the appropriate boxes on this form and return it promptly to:

X-RAY RECEIVING CENTER
ENVIRONMENTAL HEALTH SERVICE
ALFORD–Box 4258
Morgantown, West Virginia 26505

DO ALL WRITING WITH NO. 2 PENCIL
WRITE YOUR NUMERALS LIKE THIS: 1 2 3 4 5 6 7 8 9 0

1. MINER'S SOCIAL SECURITY NUMBER

2. DATE OF X-RAY: MONTH | DAY | YEAR

3. FILM QUALITY: + | + − | + = | U/R

YES: 0/- | 0/0 — IF YES, GO TO ITEM 15

NO — IF NO, COMPLETE ITEMS 5-14 AS APPLICABLE AND ITEM 15

FACILITY IDENTIFICATION

4. IS FILM COMPLETELY NEGATIVE?

5. SMALL OPACITIES—ROUNDED

a. TYPE: p | q | r

b. PROFUSION: 0/- | 0/0 | 0/1 | 1/0 | 1/1 | 1/2 | 2/1 | 2/2 | 2/3 | 3/2 | 3/3 | 3/4

c. ZONES: R | L

6. SMALL OPACITIES—IRREGULAR

a. TYPE: s | t | u

b. PROFUSION: 0/- | 0/0 | 0/1 | 1/0 | 1/1 | 1/2 | 2/1 | 2/2 | 2/3 | 3/2 | 3/3 | 3/4

c. ZONES: R | L

7. LARGE OPACITIES

a. SIZE: 0 | A | B | C

b. TYPE: WD | ID

8. PLEURAL THICKENING

a. Costophrenic Angle: 0 | R | L | BOTH

b. Diffuse: 0 | R | L | BOTH

c. Plaques: 0 | R | L | BOTH

d. Grade of b/c: 0 | 1 | 2 | 3

9. ILL DEFINED DIAPHRAGM

0 | R | L | BOTH

10. ILL DEFINED CARDIAC OUTLINE

0 | 1 | 2 | 3

11. PLEURAL CALCIFICATION

a. DIAPHRAGM: 0 | R | L | BOTH

b. WALL: 0 | R | L | BOTH

c. OTHER SITES: 0 | R | L | BOTH

d. GRADE OF a/b/c: 0 | 1 | 2 | 3

12. OTHER SYMBOLS

a. OBLIGATORY: 0 | ca | co | cp | es | tba | od — SPECIFY od

b. OPTIONAL: 0 | ax | bu | cn | cv | di | em | hi | ho | k | px | ri | tbu

OTHER — (SPECIFY OTHER)

13. COMMENTS

SEE DOCTOR

(SPECIFY REASON. HAS PRIVATE PHYSICIAN BEEN NOTIFIED?)

YES

14. OTHER COMMENTS

I understand that all the above information will be held STRICTLY CONFIDENTIAL and divulged only as specified in Part 37 of the Code of Federal Regulations 42CFR

15. FILM READER'S INITIALS

PHYSICIAN'S SOCIAL SECURITY NUMBER

DATE OF READING: MONTH | DAY | YEAR

ECA 116 (CIN) 7-70

(Continued)

1966 Revision of KS Classification of Pneumoconioses

Pathological Classification

I No evidence of disease but positive history.
II Minimal changes which fall within normal limits except for history.
III Accentuation of linear or bronchovascular markings.
IV A considerable degree of accentuation of linear or bronchovascular markings with the pattern still maintained.
V Accentuation of the linear or bronchovascular markings with a breakup of the normal pattern, such as stippling.
VI Accentuation of the linear or bronchovascular markings with an unmistakable stippling present.
VII Advanced stippling to the point of small nodulation with nodules 2-3 mm in size.
VIII Stippling and nodulation with the nodulations being larger than 3 mm.
IX Conglomeration of the nodules to any size.
X Coexisting infectious disease such as pulmonary tuberculosis.

Functional Classification

A. No symptoms referable to the chest with no loss of pulmonary function.
B. Mild symptoms with no loss of pulmonary funtion, or mild loss of pulmonary function with no symptoms.
C. Moderate loss of pulmonary function, or moderate degree of symptoms or both.
D. Marked loss of pulmonary function, or marked symptoms or both.

tion and consequently has two major parts *(see 1966 KS Classification)*. The first part is an x-ray classification and the second is a functional one.

The x-ray classification is simple and easy to understand, not only by the physicians, but also for the lawyers and ultimately for the referee who must approve the final settlement.

The functional classification is similarly simple.[4]

If an attorney has a client who is classified as Class V C, he immediately knows that there are reproducible x-ray changes sufficient to indicate disease plus enough functional disability so that return to a dusty occupation is contraindicated. The same client might be classified under the newer UICC/Cincinnati Classification as p 2/2, all zones; or q 1/2, 4 zones; or s 3/2, 5 zones; or t 2/1, all zones, or many other possibilities. This is just not practical.[5,6]

The types of occupations in which we find pneumoconioses have expanded from foundry workers and grinders to include welders, spray painters, press operators, boiler operators, steel mill workers, sand blast operators, etc. The laws become more and more liberal whenever they are amended but the net result has been so expensive for industry that every new plant is built with a greater amount of safety factors.

New foundries, which are almost impossible to keep clean, have been largely automated with controllers in dust free, air conditioned booths. Blowers and increased ventilation have been installed in new places in other factories. Some operations, such as sand blasting, are being done in enclosed booths to keep the dust from spreading, etc. Now that more and more workers are being retired in their 50's at least they will be healthy enough to enjoy their leisure time, but for those who are retiring now and who have a pneumoconiosis this classification is more helpful in determining the amount of compensation than in previous ones or than the subsequent UICC/Cincinnati Classification.

Conclusion

The 1966 KS Classification is a satisfactory one for the state of Michigan and has been used in more than 5,000 cases. It should be adopted more widely.

Undoubtedly pressure from the federal government will eventually result in the adoption of the less satisfactory UICC/Cincinnati Classification but this is many years in the future.

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Monthly Surveillance Report

Cases of Certain Diseases
Reported to the Michigan Department of Public Health
For the five-week period ending Feb. 1, 1974

MICHIGAN DEPARTMENT OF PUBLIC HEALTH

	1974 This 5-Week Period	1973 Same 5-Week Period	1974 Total To Above Date	1973 Total Same Date	Total Cases for 1973
Rubella	146	91	146	91	2,001
Cong. Rubella Syndrome	0	0	0	0	4*
Measles	167	230	167	230	4,552
Whooping Cough	9	12	9	12	86
Diphtheria	0	0	0	0	0
Mumps	920	770	920	770	5,042
Scarlet Fever & Strep Sore Throat	4,248	2,458	4,248	2,458	24,467
Tetanus	1	0	1	0	2*
Poliomyelitis (paralytic)	0	0	0	0	0
Hepatitis	413	385	413	385	3,872
Salmonellosis (other than S. typhi)	137	51	137	51	795
Typhoid Fever (S. typhi)	1	1	1	1	14
Shigellosis	93	72	93	72	623
Aseptic Meningitis	14	16	14	16	434
Encephalitis	2	11	2	11	163
Meningococcic Meningitis	4	1	4	1	54
H. Influenza Meningitis	15	7	15	7	89
Tuberculosis	132	179	132	179	1,380
Syphilis	314	364	314	364	4,328
Gonorrhea	3,157	2,763	3,157	2,763	31,128

Information can be supplied by the local health department on the local incidence of disease.

Maurice Reizen, MD, Director
Michigan Department of Public Health

*corrected totals

MSMS ACTION/Continued

Managers, and Sidney Adler, MD, Detroit, was chosen for a one-year term. Both are MSMS past presidents.

The Council voted to continue its evaluation of the proposed establishment in Michigan of a "Statewide House Officer Training System" known as SHOTS. The MSMS committee, authorized by the MSMS House of Delegates, had recommended endorsement of the proposal while expressing its desire for greater representation on the SHOTS board in proportion to the number of MSMS members and also noting that one of the objectives of SHOTS should be to stress the need for primary care residencies. The matter will be discussed again March 13.

The Council adopted a position paper on the regionalization of medical care and sent it to Gov. Milliken. The governor, in his speech to the fall House of Delegates, had requested such advice from MSMS and Council Chairman Leitch had appointed a task force to develop the paper. *(The full statement has been sent to each component president, president-elect, secretary and editor for information.)*

MSMS Speaker Vernon V. Bass, MD, of Saginaw reported that there will be no elections at the 1974 spring meeting for AMA delegates and AMA alternates, but that their terms will carry over just like those for the MSMS officers and councilors.

ANESTHETICS /Continued

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New Medical Practice Act

MSMS Committee Will Watch Implementation of Changes

Robert Stow, MD, MSMS councilor from Lansing, will chair a standing MSMS committee to oversee implementation of the new Michigan Medical Practice Act.

Council Chairman Robert Leitch, MD, announced the appointment of Doctor Stow to head the committee and said appointment of the full committee would come soon.

Doctor Leitch said the committee is charged to establish permanent liaison with the Medical Practice Board and to participate fully as the board drafts new rules and regulations to put the act into effect.

The act was signed Jan. 8 by Gov. Milliken and became effective immediately.

It replaces the 1899 licensing act for medical doctors.

Doctor Stow said he would inform the board immediately of his committee's intentions and ask for initial meetings with representatives of the board.

Doctor Stow

The new law, Public Act 185 of 1974, totally rewrites the old statutes and contains seven major changes in concept. They are:

1. Addition of a layman on the board. The board, with its name changed from Board of Registration in Medicine to Medical Practice Board, will consist now of 11 members. Ten will be physicians and one a layman. MSMS is to nominate three physicians for each physician vacancy on the board from whom the governor may choose appointees. Appointment of the public member is by the governor. All are subject to confirmation by the Senate. Terms on the board are for four years, with five physicians appointed in alternating biennial years. The public member is described as one who does not have, and never has had, a material interest in the medical profession.

2. The practice of medicine is defined as follows:

"Practice of medicine" or "to practice medicine" means to diagnose, treat, prevent, cure, or relieve a human disease, ailment, defect, complaint, or other condition, whether physical or mental, by attendance or advice, or by a device, diagnostic test, or other means, or to offer, undertake, attempt to do, or hold oneself out as able to do, any of these acts."

3. A new temporary license was established to provide licensure for faculty members of foreign medical schools who are serving temporary faculty appointments in a medical school in Michigan. The license will only protect the visiting physician during his professorial tenure in the state.

4. The concept of limited license was enacted into law. Under the section, a limited license may be issued to a physician whose license has been previously suspended or revoked. Practice under a limited license will be restricted to conditions and situations prescribed by the board. Thus, every limited license will be unique, addressing the peculiar circumstances of that particular physician. After a physician has demonstrated his capacity to perform without constraints, the Medical Practice Board may convert the limited license to a full license.

5. Also new to Michigan is Section 11, subsection (e), which is the so called "sick doctor act." This section permits the board to suspend, revoke or place on probation a physician who has demonstrated inability to practice medicine for reasons of a physical or mental condition. Under the section, the board may, upon probable cause, compel a physician to submit to a mental or

Paves Way for Innovations

physical examination. When the physician whose license has been interrupted under the "sick doctor act" can demonstrate his ability to practice medicine within reasonable standards of practice, the board shall return his license without prejudice.

6. Several changes are made with respect to educational requirements for licensure. The previously rigid requirements for passage of certain blocks of the licensure test are removed in favor of the clause, ". . . he has achieved a passing grade on a uniform examination, whose scope is determined by the board, which shall cover those general subjects the knowledge of which is commonly and generally required. . . ."

7. The words, "intern" and "postgraduate" are removed from the statute. All post-graduate training is referred to by that term. Temporary licensure is required for all post-graduate training, including the year previously recognized as internship.

The full text of the new law follows. Additional copies are available from MSMS on request.

Text of Act Spells Out Added State Options

Senate Bill No. 547, to provide for the examination, licensing, registration, and regulation of doctors of medicine; to regulate the practice of medicine; to provide penalties; and to repeal certain acts and parts of acts.

The People of the State of Michigan enact:

Sec. 1. This act shall be known and may be cited as the "medical practice act."

Sec. 2. As used in this act:

(a) "Board" means the medical practice board.

(b) "Department" means the department of licensing and regulation.

(c) "Doctor of medicine" means a graduate of a medical school with a medical doctor's degree.

(d) "License" or "license to practice medicine," when not otherwise qualified, means a license to practice medicine in this state issued under section 6 or a license issued under section 8 or 9.

(e) "Medical school" means an institution, approved by the board, offering an organized curriculum leading to the degree of doctor of medicine.

(f) "Public member" means a person who is not, or never was, a member of the profession or occupation being licensed or regulated or the spouse of any such person, or a person who does not have or never has had, a material financial interest in either the providing of the professional service being licensed or regulated or an activity directly related to the profession or occupation being licensed or regulated.

(g) "Practice of medicine" or "to practice medicine" means to diagnose, treat, prevent, cure, or relieve a human disease, ailment, defect, complaint, or other condition, whether physical or

(Continued)

mental, by attendance or advice, or by a device, diagnostic test, or other means, or to offer, undertake, attempt to do, or hold oneself out as able to do, any of these acts.

(h) "State" means a state, district, or territory of the United States, and includes the commonwealth of Puerto Rico.

Sec. 3. (1) The medical practice board is created within the department of licensing and regulation. The governor, by and with the advice and consent of the senate, shall appoint 11 resident electors of the state who shall constitute the board. The Michigan state medical society may submit to the governor its recommendations for appointments to the board, which recommendation shall consist of not less than 3 times the number of appointments to be made. The governor may appoint from this recommendation.

(2) Ten of the persons so appointed shall be a legally licensed and registered doctor of medicine of this state, and shall have been actively engaged in the practice of medicine in this state for not less than 6 years immediately preceding the time of the appointment. One member of the board shall be a public member as defined in this act. Before October 1 of each biennial period, the governor shall appoint 5 persons, who are qualified to hold public office, for 4 years, from October 1 next ensuing. A member shall be appointed for a term of 4 years and until his successor is appointed and qualified. The members of the present board shall continue to function until their terms expire and their successors are appointed and qualified. A member shall not serve for more than 3 successive terms on the board. In addition, the public member shall be appointed in the same manner as are other members of the board.

(3) After written notice and a public hearing conducted by the governor or his designated representative, the governor may remove a member of the board for misconduct, neglect of duty, or such disability as renders him unable to perform the duties of the office. The governor shall fill vacancies in the same manner as original appointments.

(4) The Board shall hold not less than 4 regular meetings in a calendar year. The board shall elect a president and a vice-president annually. A majority vote of a quorum of the board is necessary for a decision. A quorum consists of 6 members.

(5) Members of the board shall serve with compensation of $35.00 per diem, plus their actual and necessary traveling and other expenses incurred in the performance of their official duties in accordance with the standard travel regulations of the department of administration.

(6) The department shall have charge of the offices of the board and of its records and all moneys collected, shall supervise all necessary administrative work of the board, shall perform the duties usually appertaining to such offices.

(7) The records of the board shall be prima facie evidence of the proceedings of the board set forth therein, and a copy thereof, duly certified by the administrative secretary of the board, shall be admissable in evidence with the same force and effect as if the original were produced.

Sec. 4. (1) A license is required of physicians taking postgraduate medical training in this state.

(2) Postgraduate medical training may be taken only in hospitals whose training programs have been approved by the board.

(3) The board shall keep a list of hospitals approved for postgraduate medical training, and shall delete from the list a hospital that does not submit to the board within the first 10 days of a training year the name of each doctor of medicine in training in the hospital, together with the name of the medical school from which the doctor graduated, the date of his graduation, and the number of his license for training in this state.

Sec. 5. The board may:

(a) Deny, issue, limit, suspend, and revoke licenses to practice medicine, otherwise discipline holders of licenses, and reinstate licenses that have been limited, suspended, or revoked.

(b) Authorize investigations and hold hearings in connection with the denial, issuance, limitation, suspension, or revocation of licenses.

(c) Upon application to the circuit court issue a subpoena requiring a person to appear before the board and be examined with reference to a matter within the scope of the inquiry or investigation being conducted by the board and to produce books, papers, or documents pertaining thereto.

(d) Authorize a member of the board, or an agent of the board, to administer an oath to a witness in any matter before the board.

(e) Institute proceedings in its own name in the circuit court to restrain and enjoin a violation of this act.

(f) Conduct investigations to determine qualifications of applicants.

(g) Provide for the annual registration of qualified individuals licensed to practice medicine, and maintain registries of the individuals.

(h) Promulgate such rules as may be necessary to carry out the purposes and enforce the provisions of this act.

(i) Approve medical schools, hospitals, and institutions for the purposes of training specifically referred to in this act.

(j) Perform other acts and make other determinations necessary and proper in carrying out the

provisions of this act.

(k) Issue an administrative letter of reprimand to physicians licensed under this act for apparent violations thereof.

Sec. 6. An applicant for a license to practice medicine is entitled to receive a license upon paying a fee of $100.00 and satisfying the board that the applicant meets all of the following requirements:

(a) He is not less than 18 years of age.

(b) He is of good moral character.

(c) He has satisfactorily completed 60 semester hours of general study in a college or university approved by the board, or has satisfactorily completed equivalent studies.

(d) He has received the degree of doctor of medicine from a school of medicine organized and chartered under the laws of this state, or from a school of medicine approved by the board with substantially the same requirements as a school of medicine chartered under the laws of this state.

(e) He has completed 1 year of postgraduate training in a hospital or other institution approved by the board for postgraduate training.

(f) He has achieved a passing grade on a uniform examination, whose scope is determined by the board, which shall cover those general subjects the knowledge of which is commonly and generally required of candidates for the degree of doctor of medicine conferred by accredited medical colleges or schools of medicine in the United States. The board may accept, in lieu thereof, proof that the applicant has passed a substantially equivalent examination given in another state and approved by the board.

Sec. 7. An individual who is licensed to practice medicine in another state or territory of the United States and applies for a license in this state is entitled to receive a license upon paying a fee of $100.00 and satisfying the board that the individual meets all of the following requirements:

(a) He meets the requirements of section 6(a) to (e).

(b) State licensing board disciplinary proceedings are not pending against him.

(c) He is licensed to practice in another state after passing an examination deemed by the board to have been conducted in accordance with standards substantially equivalent to those applicable to examinations given by the board.

Sec. 8. (1) The board may issue a temporary annual license for postgraduate training, under the supervision or direction of a doctor of medicine, in a hospital or institution with a training program approved by the board, to a person who pays a fee of $25 and who satisfies the board that he meets the requirements of section 6(a) to (e). This license may be renewed annually for a term not to exceed 5 years.

(2) The board may issue a temporary annual license to practice medicine within an approved medical school to a person who is a citizen of a foreign country and a member of the faculty of a foreign medical school, and who holds a temporary faculty appointment in a university medical school in this state, for the purpose of training and experience prior to returning to his own country. The qualifications for licensure under this section are that the applicant have the degree of doctor of medicine and have a license or registration to practice medicine in his home country.

Sec. 9. The board may issue a limited license to practice medicine to a doctor of medicine, whose license was previously suspended or revoked by the board, upon payment of a fee of $25.00. Practice under a limited license is restricted to such conditions as are stipulated by the board. A limited license shall specify that the holder is licensed to practice medicine as prescribed by the board. A holder of a limited license shall remain under the scrutiny of the board and shall make such reports as are required by the board. A violation of the conditions under which a limited license is granted constitutes cause for suspension or revocation of the license. The board may convert a limited license to a regular or unlimited license upon application of the licensee.

Sec. 10 (1) Licenses shall be renewed on or before January 1 of each year on forms prescribed by the board and shall be accompanied by a renewal fee of $25. The reregistration form, to be signed by the applicant, shall contain his name, his residence address, the address at which he is engaged in practice, and such other identifying information as the board may require.

(2) Failure to pay the annual renewal fee on or before January 1 of each year shall operate as a forfeiture of the right of the licensee to practice medicine in this state. The license shall be reinstated without examination within 5 years from the date of forfeiture upon payment of all delinquent annual fees and a penalty fee of $10.

(3) A license which has been forfeited for more than 5 years because of nonpayment of annual renewal fees may be reinstated at the discretion of the board upon payment by the applicant of all delinquent annual fees and a penalty fee of $10.

(4) A licensee is not required to pay renewal fees while on active duty with the armed forces of the United States.

(5) A person who receives a certificate of renewal under this section shall display it in his place of practice at all times.

(6) When a person licensed under this act and

(Continued)

practicing in this state changes his place of residence in this state, or moves out of the state, he shall notify the board within 30 days of the change or move.

Sec. 11. (1) The board may revoke, suspend, place on probation, or reprimand the holder of a license, or refuse to reregister or reinstate a license for unprofessional conduct.

(2) The board may refuse to issue or continue a certificate of registration or license to a person guilty of unprofessional and dishonest conduct. As used in this act, "unprofessional and dishonest conduct" means any of the following:

(a) Permitting one's name or one's certificate of registration to be used by a person, group, or corporation when the doctor of medicine concerned is not actually in charge of or responsible for the treatment given.

(b) Failure to use reasonable care and discrimination in the administration of drugs, and failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease.

(c) Selling, prescribing, giving away, or administering drugs for other than legal and legitimate therapeutic purposes.

(d) Procuring, or aiding or abetting in the procuring of, a criminal abortion or a procedure that is not lawful in this state.

(e) Inability to practice medicine according to standards of acceptable and prevailing medical practice by reason of illness, drunkenness, excessive use of controlled substances, chemicals, or any other type of material, or as a result of a mental or physical condition. In enforcing this subdivision, the board, upon probable cause, may compel a doctor of medicine to submit to a mental or physical examination by doctors of medicine designated by it and at the expense of the board. Failure of a doctor of medicine to submit to a mental or physical examination when directed constitutes an admission of the allegations against him unless the failure is due to circumstances beyond his control, and a default and final order may be entered without the taking of testimony or presentation of evidence. A doctor of medicine affected under this subdivision shall be afforded an opportunity at reasonable intervals to demonstrate that he can resume the competent practice of medicine in compliance with standards of acceptable and prevailing medical practice. For the purposes of this subdivision, a doctor of medicine licensed under this act who accepts the privilege of practicing medicine in this state, and by so practicing or by the making and filing of an annual registration to practice medicine in this state, shall be deemed to have given his consent to submit to a mental or physical examination when directed to do so in writing by the board, and to have waived all objections to the admissibility of the testimony or examination reports of the examining doctor of medicine on the ground that the testimony or reports constitute a privileged communication.

(f) Wilfully betraying a professional secret, engaging in the division of fees for referral of patients, or accepting kickbacks on medical or surgical services, appliances, or medications purchased by patients.

(g) Advertising for or soliciting patients.

(h) Being guilty of immoral conduct.

(i) A departure from, or the failure to conform to, minimal standards of acceptable and prevailing medical practice, whether or not actual injury to a patient is established.

(j) Representing, with the purpose of obtaining compensation or other advantage for himself or for any other person, that an incurable disease or injury, or other incurable condition, can be permanently cured.

(k) Knowingly maintaining a professional connection or association with a person who is in violation of this act or rules of the board with a person who knowingly aids, assists, procures, or advises an unlicensed person to practice medicine contrary to this act or rules of the board.

(l) Making a false or fraudulent statement in applying for a license to practice medicine.

(m) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, this act or the rules of the board.

(n) The obtaining of, or attempting to obtain, money or any thing of value by fraudulent misrepresentations in the course of the practice of medicine.

Sec. 12. (1) The board may revoke or suspend the license of a licensee who is convicted of a felony or misdemeanor in the course of his practice.

(2) If the holder of a license to practice medicine granted pursuant to this act is adjudged to be mentally incompetent in a proceeding in a court of this or another state, or in a federal court, his license and registration may be revoked, limited, or suspended. The license may be subsequently reinstated at the discretion of the board. If the court in which the adjudication takes place is a court of this state, the clerk of the court shall transmit to the board a certificate of adjudication.

Sec. 13. (1) An application for reinstatement of a license which is revoked may be made to the board not less than 6 months after the revocation. The board shall grant a hearing within a reasonable time following the application for reinstatement.

(2) The board may grant the reinstatement of

a revoked license or grant a limited license if, after a hearing, it is satisfied that the applicant is of good moral character, is able to perform medical services with reasonable skill and safety to the patient, and should be permitted in the public interest to resume the practice of medicine. As a condition to the reinstatement of a license, the board may impose any disciplinary or corrective measure authorized under this act.

Sec. 14. (1) A license to practice medicine of the kind which may be issued under this act, heretofore legally issued in this state and valid when this act takes effect, shall have the same force as similar licenses issued under this act. The license is subject to the same authority of the board to revoke, limit, suspend, or reinstate as a similar license issued under this act.

(2) Proceedings to revoke, suspend, or limit a license or otherwise to discipline the holder of a license shall not abate by reason of the passage of this act.

(3) The holder of a license heretofore legally issued in this state is subject to the same disciplinary proceedings to which a holder of a license issued under this act is subject.

Sec. 15. The promulgation of rules, the procedures in a hearing involving the granting, denial, revocation, suspension, or limiting of a license issued under this act, appeals from a board decision, and the issuance of interpretive statements and declaratory rulings shall be pursuant to Act No. 306 of the Public Acts of 1969, as amended, being sections 24.201 to 24.315 of the Michigan Compiled Laws.

Sec. 16. (1) Under the circumstances described and subject in each case to the limitations stated, the following persons are exempt from licensure to practice medicine under this act:

(a) A medical officer of the armed services of the United States, of the United States public health service, or of the veterans administration, holding a degree from a medical school but not licensed to practice medicine in this state, while engaged in the performance of his official duties.

(b) An individual authorized to practice medicine in a foreign country, employed by the public health service maintained by the government of the foreign country for the exclusive use of members of its merchant marine and members of its consular and diplomatic corps, while caring for such members in the performance of his official duties.

(c) A doctor of medicine residing in another state or country and authorized to practice medicine there who, in an exceptional circumstance, is called in consultation by a doctor of medicine licensed in this state, or who, for the purpose of furthering medical education, is invited by a medical school approved by the board or by a recognized medical organization to conduct a lecture, clinic, or demonstration, so long as he does not open an office or designate a place to meet patients or receive calls within the state.

(d) A doctor of medicine authorized to practice medicine in another state or country, or a medical officer described in subdivision (a) of this section, or an individual who meets the requirements of subdivision (d) of section 6, while rendering medical care in a time of disaster or while caring for an ill or injured individual at the scene of an emergency.

(e) A student in training in a medical school approved by the board while performing the duties assigned to him in the course of his training.

(f) A person qualified by education, training, and experience who performs selected acts, tasks, or functions under the direction and control of a licensed doctor of medicine.

(g) A person licensed under other laws of this state to the extent authorized by his license.

(h) Osteopathic physicians licensed under the provisions of Act No. 162 of the Public Acts of 1903, as amended, being sections 338.101 to 338.109 of the Michigan Compiled Laws.

(2) Except as provided in subsection (1) it is unlawful for a person to practice medicine in this state without a license under this act. A person convicted of violating this subsection is guilty of a felony, and upon conviction thereof shall be fined not less than $1,000.00 nor more than $5,000.00, or imprisoned for not less than 1 year nor more than 5 years, or both, and shall forfeit rights and privileges obtained and conferred by virtue of such registration.

Sec. 17. This act or rules promulgated pursuant thereto do not apply to a person who, in good faith, ministers to the sick or suffering by spiritual means alone, through prayer, in the exercise of a religious freedom, if he does not use or prescribe drugs, medicine, or surgery or assume the title of, or hold himself out to be, a physician or surgeon.

Sec. 18, Act No. 237 of the Public Acts of 1899, as amended, being sections 338.51 to 338.59 of the Compiled Laws of 1970, is repealed.

This act is ordered to take immediate effect.

Signed into law by
Gov. William G. Milliken
Jan. 8, 1974

Mediscene

March 26-27—Colposcopy seminar, University of Kentucky Medical Center, Lexington, contact: Ronald D. Hamilton, MD, Director, Continuing Education, College of Medicine, University of Kentucky, Lexington, Ky. 40506.

March 25-28—Second annual spring meeting, featuring eight postgraduate courses, sponsored by the American College of Surgeons, in Houston, contact: ACS, 55 E. Erie St., Chicago, Ill. 60611.

March 27-28—Annual Michigan Conference on Maternal and Perinatal Health, the Pantlind Hotel, Grand Rapids, contact: Lloyd Kammeraad, MD, 1810 Wealthy St., SE, Grand Rapids, Mich. 49506, or Helen Schulte, MSMS Headquarters.

March 29-31—Continuing medical education workshop in human sexuality sponsored by the Michigan Psychiatric Society in collaboration with the Department of Psychiatry, Sinai Hospital, Detroit, at Sinai Hospital, accredited by the American Academy of Family Physicians, AMA accreditation requested, contact Ms. Diane Fleming, Registrar, Room 228 Blumberg Professional Bldg., 14800 W. McNichols Rd., Detroit, Mich. 48235.

March 31-April 6—Introductory course in "Functional Corrective Surgery of the Nasal Septum and the External Nasal Pyramid," "Rhinomanometry and Naso-antral Manometry" and "Basic Principles of Respiratory Physiology and Fundamental Diagnostic Tests," sponsored by the American Rhinologic Society and the Illinois Masonic Medical Center, Chicago, at the center, contact: R.P. Gustafson, Illinois Masonic Medical Center, 836 Wellington Ave., Chicago, Ill. 60657.

April 1-3—Third National Congress on the Quality of Life, the Later Years, sponsored by the AMA in cooperation with other organizations, at the Marriott Motor Hotel, Chicago, contact: Congress Coordinator, AMA, 535 N. Dearborn St., Chicago, Ill. 60610.

April 11—Ninth Annual Conference on the Medical Aspects of Organized Athletics, sponsored by MSMS, at Grand Valley State Colleges, Allendale, contact: Helen Schulte, MSMS Headquarters. *(Note a new date and location for the conference.)*

April 18-20—Critical care symposium on "Pulmonary Function and Blood Gas Changes in Critically Ill and Injured Patients," sponsored by the Department of Surgery of the Wayne State University School of Medicine at the Wayne County Medical Society Headquarters, 1010 Antietam, Detroit, contact: Robert F. Wilson, MD, FACS, Professor of Surgery, WSU School of Medicine.

April 20-21—Postgraduate seminar on "Vascular Disease for the Practicing Physician," sponsored by the Department of Surgery, Medical College of Wisconsin, at the Pfister Hotel, Milwaukee, contact: Victor M. Bernhard, MD, Medical College of Wisconsin, 561 N. 15th St., Milwaukee, Wis. 53233.

April 22-25—Annual Spring Session of the American Academy of Pediatrics, Americana Hotel, Bal Harbour, Fla., contact: AAP offices, 1801 Hinman Ave., Evanston, Ill. 60204.

April 24—Annual Legislative Day, MSMS Auxiliary, at Olds Plaza Hotel, Lansing, contact: Mrs. Robert J. Westerhoff, 2458 Maplewood, SE, Grand Rapids, Mich. 49506.

April 24-25—Annual Spring Conference, MSMS Auxiliary, at Hospitality Inn, Lansing, contact: Mrs. William J. Jones, president, 15839 Crescent Drive, Allen Park, Mich. 48101.

April 25-27—27th National Conference on Rural Health sponsored by the AMA Council on Rural Health at the Detroit Hilton Hotel, contact: Bond L. Bible, PhD, Department of Rural Health, AMA, 535 N. Dearborn St., Chicago, Ill. 60610.

April 25-28—Annual convention, American Association of Medical Assistants, State of Michigan, Detroit Hilton Hotel, contact: Virginia Doyle, 1484 Southfield Rd., Birmingham, Mich, 48009.

April 28-May 3—Annual conference of the National Council on Alcoholism, sponsored by the NCA and its affiliates, in Denver, contact: Mrs. Ann Milata, NCA, 2 Park Ave., New York, N.Y. 10016.

April 29-May 2—Twenty-second Annual Clinical Meeting of the American College of Obstetricians and Gynecologists, Las Vegas, contact: Donald F. Richardson, Associate Director, ACOG, 1 E. Wacker Dr., Chicago, Ill. 60601.

May 1-3—Annual meeting of the Michigan Public Health Association, Detroit Hilton, contact: Anna Lampela, MPHA, 403 Seymour Ave., Lansing, Mich. 48914.

May 1-3—American Cancer Society's National Conference on Advances in Detection and Diagnosis of Cancer, at the Denver Hilton, Denver, Colo., approved for AMA and AAFP postgraduate credit, contact Evadne Gerrard, American Cancer Society, 219 E. 42nd St., New York, N.Y. 10017.

May 2-3—Annual session and scientific program, Michigan Heart Association, Cobo Hall, Detroit, contact: Marilyn Janes, Michigan Heart Association 16310 12 Mile Rd., Southfield, Mich. 48076.

May 2-5—Annual Meeting of the American Society of Internal Medicine, Hyatt Regency Hotel, San Francisco, contact: ASIM office, 535 Central Tower Bldg., San Francisco, Calif. 94103.

May 5—MSMS Council, Boyne Falls, contact: Warren F. Tryloff.

May 5-7—1974 Annual Session, MSMS House of Delegates, at Boyne Mountain Lodge, Boyne Falls, contact: Richard Campau, MSMS Headquarters.

May 6-10—Scientific session sponsored by the American Psychiatric Association in Cobo Hall, Detroit, contact: Walter E. Barton, MD, 1700 18th St. NW, Washington, D.C. 20009.

May 9-10—Seventeenth Annual Clinic Days of Children's Hospital of Michigan, postgraduate meeting on pediatric infectious diseases, cosponsored by the Wayne State University School of Medicine, contact: Adnan Dajani, MD, Children's Hospital of Michigan, Detroit Medical Center, 3901 Beaubien Blvd., Detroit, Mich. 48201.

May 10-11—Seventh Annual Cancer Symposium, on "Management of Ovarian Malignancy," sponsored by the Wayne State University School of Medicine in co-sponsorship with the American Cancer Society—Michigan Division and the Michigan Cancer Foundation, at Gordon Scott Hall, WSU Medical School, contact: Mrs. Dorothy Bewley, Cancer Symposium Registrar, 4160 John R St., Detroit, Mich. 48201.

May 18-25—Annual Michigan Week, sponsored by the Greater Michigan Foundation, with 15,000 volunteers taking part, for information on events, contact: Greater Michigan Foundation, 809 Center St., Lansing, Mich. 48905.

May 24-25—Thirteenth Annual Kidney Disease Symposium sponsored by the Kidney Foundation of Michigan in cooperation with Henry Ford Hosptial, in Buerki Auditorium, Detroit, contact Nathan W. Levin, MD, chairman, Kidney Foundation of Michigan, 3378 Washtenaw Ave., Ann Arbor, Mich. 48104.

May 27-31—Postgraduate course in "Practical Therapeutics in Internal Medicine," sponsored by the University of Kentucky Medical Center and the American College of Physicians, at Lexington, Ky., contact: Ronald D. Hamilton, MD, College of Medicine, University of Kentucky, Lexington, Ky. 40506.

June 1-5—Advanced continuing education workshop on "Plastic Surgery of the Aging Face," sponsored by the Department of Otolaryngology. Abraham Lincoln School of Medicine, University of Illinois, in cooperation with the American Academy of Facial Plastic and Reconstructive Surgery in Chicago, contact: Department of Otolaryngology, Eye and Ear Infirmary, 1855 W. Taylor St., Chicago, Ill. 60612.

June 12—MSMS Council, MSMS Headquarters, contact: Warren F. Tryloff.

June 16-20—AMA House of Delegates and Clinical Convention, Chicago, contact: AMA, 535 N. Dearborn St., Chicago, Ill. 60610.

June 16-27—1974 Summer Program in Human Sexuality, sponsored by the Indiana University Institute for Sex Research, in Bloomington, Ind., contact: Institute for Sex Research, 416 Morrison Hall, Indiana University, Bloomington, Ind. 47401.

July 6-10—Michigan Academy of Family Physicians Annual Meeting and Scientific Program, Park Place Motor Inn, Traverse City, contact: MAFP office, 933 Wing St., Plymouth, Mich. 48170.

July 22-24—Ninth annual continuation course in "Current Practice of Clinical Electroencephalography," sponsored by the American Electroencephalographic Society, in Seattle, Wash., contact: Donald W. Klass, MD, Mayo Clinic, Rochester, Minn. 55901.

Aug. 1-3—MSMS Council, St. Clair Inn, St. Clair, contact: Warren F. Tryloff.

Sept. 4-6—International Conference on the Physician and Population Change, sponsored by the World Medical Association in cooperation with other organizations, in Stockholm, Sweden, contact: Sir William Refshauge, Secretary General, World Medical Association, 10 Columbus Circle, New York, N.Y. 10019.

Sept. 23-27—Family practice review, sponsored by the Michigan Academy of Family Physicians, at Scott Hall, Wayne State University School of Medicine, contact: MAFP office, 933 Wing St., Plymouth, Mich. 48170.

Sept. 25—MSMS Council, MSMS Headquarters, contact: Warren F. Tryloff.

Oct. 9-10—109th Scientific Session, sponsored by MSMS, at the Sheraton-Cadillac Hotel, Detroit, contact: Helen Schulte, MSMS Headquarters.

Nov. 6—MSMS Council, MSMS Headquarters, contact: Warren F. Tryloff.

Nov. 21-24—Annual Meeting of the American Association for Clinical Immunology and Allergy, at Ft. Lauderdale, Fla., contact: John L. Dewey, president-elect, AACIA, PO Box 912, Omaha, Neb. 68101.

Dec. 11—MSMS Council, MSMS Headquarters, contact: Warren F. Tryloff.

Socio-Economic

Nixon Proposes National Health Plan

By Bruce Ambrose, Manager, MSMS Department of Governmental Relations

President Nixon's proposal for national health insurance received more than the usual attention when it was introduced Feb. 6 and deserves close watching in the national legislative process.

Less than the Kennedy Health Security bill, but far more extensive then AMA's Medicredit, the administration program would have three parts:

1. Employees would be covered under an Employee Comprehensive Health Insurance Plan.

2. Unemployed and low income persons would be covered under an Assisted Health Plan.

3. Medicare would be expanded and amended to conform with benefits of the other two plans.

The plan proposes to enhance HMO development by citing HMOs as an optional form of medical care delivery. PSRO would provide review services. Certificate-of-need is required through state mechanisms, and health insurance companies would fall under rate review.

The proposal was introduced in the House of Representatives by Congressmen Wilbur Mills and Herman Schneebeli as H.R.12684, and in the Senate by Senator Robert Packwood as S.2970.

In his message, the president said his plan would "assure fair reimbursement for physician services, drugs and institutional providers, including a prospective reimbursement system for hospitals." He concluded his remarks by stating, "Let us continue to have doctors who work for their patients, not for the federal government. Let us build upon the strengths of the medical system we have now, not destroy it."

Proposed benefits include: hospital care, inpatient and outpatient physician care, drugs, laboratory tests and x-rays, medical devices, ambulance services and ancillary health care. Coverage would be for all illnesses and conditions, including mental illness, alcoholism and drug addiction. In addition to other benefits, children would be eligible to receive preventive care to age six, eye and hearing examinations and regular dental care to age 13. Catastrophic coverage would carry with it a maximum annual deductible of $1,500 per family. Enrollment would be voluntary.

Program enrollees would be identified by a credit card type of healthcard, with providers being compensated by an insurance carrier which would, in turn, collect from the patient any deductible or co-payments.

The Employee Plan specifies that the employer would pay 65 per cent of the premium during the first three years and 75 per cent thereafter. The covered employee, in addition to his portion of the premium, would be responsible for the first $150 each year in medical costs and $50 in drug costs. After the deductibles have been met, the employee would pay 25 per cent of the bills up to an annual maximum of $1,500 at which point the catastrophic coverage would take over. The administration estimates that the annual premium cost to the employee would be $150, and to the employer, $450.

The Assisted Medical Plan, which would replace Medicaid, carries an estimated federal cost of 6.9 billion dollars with an additional 1 billion dollars to be paid by the states.

The present Medicare program would be modified to include the benefits in the other two plans. Medicare beneficiaries would pay the first $100 of medical costs and $50 of drug costs each year with an annual $750 ceiling on out-of-pocket expenses.

Citing the climbing costs of health care, the president proposed four cost control measures. The first is a requirement that coverage by an HMO be offered to enrollees whenever and wherever such facilities become operational. Second, services rendered under the program would be reviewed by PSROs. Third is a state review of health facility construction to prevent overbuilding of hospitals and other care facilities. Fourth, states would review insurance companies for the purpose of approving specific plans, overseeing rates, ensuring adequate disclosure and take such other steps as appropriate.

AMA Continues Medicredit Support

How are your Medicredit facts? If you aren't sure, check these facts for answers to questions you may have, or may be asked.

Medicredit is the Health Care Insurance Act proposed by the American Medical Association. Its purposes are:

- To give every American under the age of 65 access to high quality care regardless of ability to pay (over 65—Medicare still would apply).
- To provide comprehensive medical and health protection for both ordinary and catastrophic expenses.
- To assure choice of physicians and flexibility of protection plans (a choice of private health insurance, prepayment insurance or prepaid group practice plans).

The responsibility for payment would be allocated between the individual and the federal government. Using federal income tax liability as a base, a sliding scale from total government payment of health care needs for the poor to 10 per cent of basic plus catastrophic coverage for the financially able.

Provisions of the plan include:

- Basic coverage of 60 days in hospital or 120 in extended care facilities each twelve months.
- Catastrophic coverage to take over where basic ends to insure 365 days per year care where required.
- Unlimited psychiatric care.
- Accent on preventive care including physical examinations, inoculations, x-ray and lab work, emergency care, dental care for children, emergency dental care for adults, all medical services by physicians and osteopaths.
- Both inpatient and outpatient care to cover all care customarily provided plus complete diagnostic services.
- Home health care including home nursing care, therapy and medical appliances.
- Ambulance services.

Protections against abuse both by recipients and by carriers include:

- Deductible provisions on a sliding scale (except for the very poor) to keep costs reasonable and prevent abuse of the program.
- Required approval of carriers to assure national standards.
- Prohibition of exclusions for preexisting conditions.
- Requirement that all protection plans must guarantee renewability.

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PRESIDENT'S PAGE/Continued

Lest you worry that this approach might dilute your professional capacity, I believe the patient can judge only how he wants health care delivered. I cannot envisage his telling you what drug or treatment program you should elect to prescribe. On the other hand, we say medicine must be delivered in our office or hospital setting; if this does not provide the basis for an adequate volume of medical services, perhaps other modes of delivery could be developed, given the resources of the entire community.

The energy shortage prompts us to think that we should consider taking medical care to the people, instead of the reverse, which has been true throughout our professional careers.

Again, about possible dangers of this proposition, I see the militant movements of the past decade as subsiding, and medicine might find the consensus not a threat, but really an ally, especially if bureaucratic pressures become illogical in the future.

It goes without saying that consumer input can only be effective if the right people are the representatives. But given this premise, I feel that consumerism in medical care is worthy of consideration.

What is your consumer I.Q.?

Brooker L. Masters, MD

Briefly Noted

J. Kenneth Altland, MD, of Lansing,

has announced his retirement as a medical consultant in the Michigan Department of Social Services after 28 years of government service. Doctor Altland is a former Michigan Health Commissioner and was the first head of the Medicaid program in the state. Doctor Altland was graduated from the University of Michigan Medical School. He served as a lieutenant commander in the coast guard during World War II and is a past secretary of the Barry County Medical Society and past president of the State and Territorial Directors of Local Health Services.

Leonard F. Bender, MD, of Ann Arbor,

is serving as president of the American Academy of Physical Medicine and Rehabilitation. The academy will hold its annual meeting Nov. 17-22 in San Francisco.

James C. Breneman, MD, of Galesburg, and Sidney Friedlaender, MD, of Southfield,

are among program leaders for the 30th annual congress of the American College of Allergists to be held April 17 through 21 in Paris. Doctor Friedlaender, who is a member of the Food and Drug Administration's Review Panel on Bacterial Vaccines and Antigens, will give a report on the status of bacterial vaccines and chair a panel discussion on the same subject. Doctor Breneman will give a report on sublingual testing.

Michael J. Brennan, MD, of Grosse Pointe,

has been appointed by Gov. Milliken to the state Public Health Advisory Council. His appointment, subject to senate confirmation, is for a term running through May, 1976.

Ronald Chen, MD, of Flint,

has been elected chairman of the National Academic Resource Council, based at Tulane University, to plan a curriculum for leadership training in community service administration. Doctor Chen, clinical professor of psychiatry at Michigan State University and commissioner of Genesee County Mental Health Services, also has been named project director of a leadership training program for foreign medical graduates serving residencies in psychiatry, supported by the National Institute of Mental Health and the American Psychiatric Association.

William T. Davison, MD, of Port Huron,

has been named acting director of the St. Clair County Health Department, replacing Robert E. Rowe, MD, who retired from the post in January.

E. Marshall Goldberg, MD, of Flint,

has just published a new novel, *The Anatomy Lesson,* issued by G. P. Putnam's Sons. Doctor Goldberg also has published *The Karamanov Equations.* Doctor Goldberg is director of medical education at Hurley Hospital in Flint.

Five Grand Rapids Physicians

were honored recently by the Rotary Club of Grand Rapids for their work in setting up emergency on-scene care for heart attack victims. They are Frederick A. Doornbos, MD; Ramon B. Lang, MD; Lee R. Pool, MD; C. Mark Vasu, MD, and John R. Wilson, MD.

Elisha S. Gurdjian, MD, of Detroit, and

the late Prof. Herbert R. Lissner, are honored in the naming of the new Gurdjian-Lissner Biomechanics Laboratory in the Wayne State University School of Medicine's medical research building. A plaque in their honor was unveiled recently when the laboratory was dedicated. Doctor Gurdjian, who received an MSMS award of commendation in 1972, retired in 1970 as chairman of the WSU School of Medicine's department of neurosurgery. He and Prof. Lissner, who headed the department of engineering mechanics at the WSU College of Engineering, began research into head injuries and their causes 30 years ago.

Andrew D. Hunt, Jr., MD, of East Lansing,

dean of the Michigan State University College of Human Medicine, will be a speaker at the Anglo-American Conference on Continuing Medical Education April 8 through 10 in Chapel Hill, N.C. Dean Hunt will discuss "Evaluation and Relicensure in the USA." The conference is sponsored by the Royal Society of Medicine, London; the Royal Society of Medicine Foundation, New York, and the University of North Carolina School of Medicine.

Jose J. Llinas, MD, of Lansing,

will leave his post as psychiatric director of the Clinton, Eaton and Ingham Community Mental Health Board July 1 to accept a similar position

with the Northcentral Florida Community Mental Health Board in Gainesville, Fla. He also is to serve as professor of psychiatry and community medicine at the University of Florida.

Bernard H. Marks, MD, of Grosse Pointe Woods,

has been appointed chairman of the department of pharmacology at the Wayne State University School of Medicine. He formerly was chairman of the pharmacology department at Ohio State University, where he received his medical education. Doctor Marks is a member of the editorial board and a field editor for the *Journal of Pharmacology and Experimental Therapeutics.*

William Martel, MD, of Ann Arbor,

will present a program on "Radiologic Diagnosis of Common Skeletal Diseases" during the 55th annual session of the American College of Physicians April 1-4 in New York City. Doctor Martel is a member of the faculty of the University of Michigan Medical School.

John P. Newton, MD, of Grand Rapids,

has been elected secretary of the Grand Rapids Committee for Project Hope. The Grand Rapids Committee recently donated two major pieces of hospital equipment, a portable operating room light and a Bovie electrical surgical unit, to be used at Sage Memorial Hospital, the site of a Project Hope program for Navajo Indians in Ganado, Ariz.

John P. Papp, MD, of Grand Rapids,

is the author of an article on "Endoscopic Experience in 100 Consecutive Cases with the Olympus GIF Endoscope" appearing in the November, 1973, issue of the *American Journal of Gastroenterology.*

D. Henry Ruth, MD, of Mason,

has been appointed to head the Family Practice Clinic at Mason General Hospital, which is affiliated with the family practice residency program at Lansing's Sparrow Hospital. Doctor Ruth received his medical education at the University of Pennsylvania and formerly, while in private practice in Pennsylvania, served as assistant clinical professor in family practice at the Hahnemann Medical School and chairman of the department of family practice at Grandview Hospital, Sellersville, Pa.

Clarence M. Schrier, MD, of Kalamazoo,

has retired as superintendent of the Kalamazoo State Hospital after 38 years of public service in the mental health field. Doctor Schrier first visited the hospital as an extern while attending the University of Michigan Medical School and returned to devote his professional career to service to the institutionalized mentally ill.

Gene D. Tang, MD, of Traverse City,

has invited interested physicians to learn more about the new Michigan Society for Infection Control, which was formed last October by a group of doctors, nurses, microbiologists and others interested in and working in the field of infection control. Membership applications are available from Sue Carpenter, RN, Infection Control Nurse, St. Joseph Hospital, Flint, Mich. 48503.

John H. Tanton, MD, of Petoskey,

has been reappointed to the Michigan Wilderness and Natural Areas Advisory Board by Gov. Milliken. Doctor Tanton, an ophthalmologist with Burns Clinic in Petoskey, was given a one year appointment on the board when it was created under a 1972 act. The new appointment is for a term running through January, 1977.

Jeremiah G. Turcotte, MD, of Ann Arbor,

has been named chairman of the University of Michigan Department of Surgery, succeeding Charles G. Child, III, MD. Doctor Turcotte, who was graduated from the U-M Medical School in 1957 and completed an internship and a residency in surgery at the U-M Hospitals before joining the faculty there in 1963. A general surgeon who has specialized in kidney transplants and surgical treatment of liver disease, Doctor Turcotte heads a staff of 43 full time faculty surgeons and 47 clinical associates in his new position.

E. Gordon Yudashkin, MD, of Laingsburg,

has announced his resignation, effective in June, as director of the Michigan Department of Mental Health.

Interest in Acupuncture Grows, Here Is Summary of Official Views in Michigan

By Susan Berman

A study of statements on acupuncture from four official agencies of state government discloses discrepancies which may eventually be settled by the courts.

The Michigan Medical Practice Board has offered this view:

"The practice of acupuncture constitutes the practice of medicine, requiring the practitioner . . . to be licensed by the Medical Practice Board . . . the practice of acupuncture is a treatment method requiring further investigation. Such investigation should be carried out only in medical centers, hospitals or other institutions capable of pursuing human medical research and having suitable committees who provide the necessary peer review of protocols and appropriate monitoring of the studies."

The Michigan attorney general's office has approved this statement as within the legal bounds of the Medical Practice Act.

The Board of Osteopathic Registration and Examination has declared that "Acupuncture is presently in the experimental stages" and "the board does not condone its use at this time."

The osteopathic board has stated that licensed osteopathic, allopathic or dental practitioners who wish to investigate acupuncture should do so only with review and approval from a review committee at an institution able to provide supervisory guidance.

The position of the Michigan Board of Chiropractic Examiners differs, and it has said: "The oriental principles of therapeutics as applied to the nervous system are in fact part and parcel and related to the practice of chiropractic as taught in this country. Therefore, acupuncture as it is known in the news media today shall be considered by this board to be one of the techniques to be used by the licensed chiropractic physician in managing disorders of the nervous system." The chiropractic board, according to a spokesman, sees acupuncture as another modality of treatment which can be put in use today by any of the licensed professions.

The differences of view expressed by the medical and osteopathic boards on one hand and the chiropractic board on the other are of concern to the agencies involved although there is presently little effort toward reconciliation of the disagreements. The results of ongoing acupuncture research as well as the reports of doctors and patients who have experience with acupuncture treatment may help to clarify the place of acupuncture in the healing arts during the next few years. In the meantime, failing an accommodation between the two sides of the question, the courts will most likely be final arbiter.

Official bodies in other states have taken positions on acupuncture similar to that of the Michigan Medical Practice Board. The New York board says that acupuncture may be performed lawfully "only by or under the direct supervision of a physician licensed in this state and in an institution appropriate for human research." California legislators have passed a statute, supported by the California Medical Association, concerning the practice of acupuncture by an unlicensed person stipulating that "it must be done in an approved medical school; carried on for the primary purpose of research, and under the supervision of a licensed physician and surgeon." In addition, the medical

(Continued on Page 170)

Research Report

All parties involved in the acupuncture picture agree that further research is warranted and necessary. Although not comprehensive, here is a report on research related to Michigan medical schools.

At Michigan State University, the Department of Biomechanics is using acupuncture methods in a study of low resistance points on the skin. Researchers are interested in a possible direct therapeutic use of acupuncture as part of peripheral stimulation therapy.

The Department of Neurology at the University of Michigan hopes soon to launch a controlled study on the efficacy of acupuncture for relief of headache pain.

The work in acupuncture of Pang L. Man, MD, and Calvin H. Chen, MD, faculty members at the Wayne State University School of Medicine, was reported in the January issue of ***Michigan Medicine.***

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Final classification of the less-than-effective indications requires further investigation.

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Warnings: Caution patients about activities requiring alertness (e.g., operating vehicles or machinery). Warn patients of possible additive effects with alcohol and other CNS depressants.

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Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

Dosage and administration: ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid,* 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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PRECAUTION: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Complete literature available on request from Professional Services Dept. PML.

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Education

Family Practice Exam Set for October

The American Board of Family Practice has announced that its next two-day written certification examination will be given Oct. 19 and 20 in five centers geographically distributed throughout the United States. Applications must be filed with the board office by June 15.

Information and application forms are available from Nicholas J. Pisacano, MD, secretary, American Board of Family Practice, University of Kentucky Medical Center, Lexington, Ky. 40506.

Workshop to Study Effects of New Health Care Training

The University of Michigan will sponsor an invitational workshop on "Changing Roles and Relationships for Health Professionals" March 27 at the Towsley Center in Ann Arbor. The workshop will look at new educational programs and examine the role relationships, legal status and economic issues involved in the use of nurse practitioners and physicians' assistants in ambulatory care settings in Michigan.

Among speakers will be Louis R. Zako, MD, of Dearborn Heights, a member of the MSMS Council and president of the Michigan Academy of Family Physicians.

WSU Medical School Reports New Grants

The National Foundation-March of Dimes has granted $25,800 to Wayne State University for continuation of the birth defects program at the Mott Center for Human Growth and Development. The program, now in its fourth year, is under the direction of T. N. Evans, MD, chairman of the department of obstetrics and gynecology at the WSU School of Medicine.

WSU also has received an award of $27,670 from Sinai Hospital for renewal of research into responses to implanted artificial heart assist devices.

In another grant renewal, the United States Public Health Service will provide $390,096 for continuing research projects in blood clotting.

Other UPHS grants to the Wayne medical school include $98,245 for support of a specialized cancer research center in radiation therapy, planned for the Detroit Medical Center; $64,245 for research in derivatives of prothrombin, $31,781 for biological studies in human melanomas and $28,078 for a study of fatty acids as related to heart disease.

MSU Health Careers Day Scheduled for April 6

Michigan State University has invited high school and junior high school students interested in education for health care professions to visit the East Lansing campus April 6 for a tour of medical education facilities.

Last year 6,000 young visitors took part in a similar program. It is sponsored by the MSU Organization of Health Professions Students and the Michigan Health Council.

The program is coordinated by the Biology and Medicine Section of MSU Information Services.

State Provides Funds for Medical Education

Act No. 115, Public Acts of 1973, authorizes appropriations to state institutions of higher education for the fiscal year ending June 30, 1974.

The budgets allocated for the three medical schools and the one osteopathic school are as follow:

University of Michigan Medical School: $7,157,600

Wayne State University School of Medicine: $10,902,500

Michigan State University College of Human Medicine: $5,175,400

Michigan State University College of Osteopathic Medicine: $3,280,800

The budget also appropriates $48,000 to Saginaw Valley College to develop a master's degree program in human biology.

There also is a $100,000 appropriation to the Upper Peninsula Health Planning Project.

Medical Education and Practice Need Close Relationship

By John S. Millis, PhD, President, National Fund for Medical Education, Cleveland

Doctor Millis explored the future of medical education and the role the county medical society can play in a recent address to members of the Ingham County Medical Society in Lansing. Following are excerpts from his address.

The education of the future physician is long, running between eight or nine years following graduation from college. Thus the medical students of today will not be in independent practice until 1980 or beyond. Their education should be for patient needs of the 1980s, the 1990s and the 21st century. The first responsibility of medical education is for the future.

The form of medical education should be changing continuously, i.e., evolving in order to educate for the future, not for the past or even the present. There seems to be little disagreement about this statement. But the important question is "changing how?"

The information of the university medical center on patient needs of the future is largely in the realm of "what can be done." The medical school is the locus of the great majority of biomedical research. Knowledge gained today through research does define the art of the possible in the future. However, biomedical research having assisted in the solution of the common diseases is now at work on those conditions with an ever decreasing incidence, the exotic conditions, sometimes with an incidence of one in a hundred thousand.

Congruency Ends

For fifty years, from 1910 to 1960, "what can be done" has been largely "what needs to be done." There was congruency between patient needs and the developing knowledge and skill of the physician. Both research and practice were greatly concerned with diseases of infancy, infectious disease, tuberculosis, anemia and metabolic disorders. In the 1960s the great unsolved health problems became those of chronic disease, mental disease, hypertension, atherosclerosis, alcoholism, obesity and drug abuse. No longer are patient needs and biomedical research fully congruent.

Medical care and therefore medical education ought to be determined by "what should be done." "What should be done" is the reconciliation or the product of "what can be done" and "what needs to be done." These two will not meet and be reconciled until medical education and medical practice are intimately related. The required relationship must be one of constant communication—that is a constant feedback from practice to education. Another way to say it is to ask for a true continuum of medical education which is circular in that educators and practitioners are in constant communication and interchange.

"What needs to be done" cannot be fully determined from observation in a university hospital or in an acute hospital. It can be determined only by the regular accumulation of the data of the current activities of all practicing physicians. Such an accumulation would describe the epidemiology of the community. It would state the current health needs of patients. It would not be a retrospective report of the epidemiology of the past, but rather a running account of the present. It would also forecast the trends for the future.

County Society Role

I come now to the consideration of the role of the county medical society in medical education. A county society could insist upon complete public health records for its community. A society could work for a common system of medical records for all physicians and for meaningful data processing using the capacity of modern computer technology. The county society could establish an intimate relationship with the Department of Epidemiology at the local medical school. The county society could ask that knowledge about the health needs of the community be used in developing the programs of continuing medical education.

In making these suggestions I do not urge that the county medical society undertake full responsibility for all of the activities mentioned. I do, however, suggest that there is a responsibility for leadership in all of them. A county society is a voluntary association of great prestige in the community. Its opinions have substantial weight with government and with individuals. It has the status required for leadership in all matters of health. Perhaps the most important matter of health is the character and the quality of the education of the physician.

Welcome

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

Richard W. Antemann, MD, 5388 Foxcroft, Kalamazoo 49002

John B. Atwater, MD, Dir. Public Health, Washtenaw County Bldg., Ann Arbor 48108

George N. Baldwin, MD, 408 Wildwood, Jackson 49201

B. G. Byakod, MD, Box A, Kalamazoo State Hosp., Kalamazoo 49001

Rodney F. Carlson, MD, 1125 Worcester Dr., NE, Grand Rapids 49505

Robert I. Cutcher, MD, 2433 Black River St., Deckerville 48427

Q. Michael Ditmore, MD, Alpena General Hosp., Alpena 49707

Peter D. Eisenberg, MD, 916 Wick Court, East Lansing 48823

David G. Flagler, MD, 1631 Gull Rd., Kalamazoo 49001

T. Eduardo Garcia, MD, 35 S. Johnson St., Pontiac 48053

Farideh Hosseini, MD, 919 W. Cross Blvd., Ypsilanti 48197

Yash Pal Kapur, MD, College of Human Med., Michigan State University, East Lansing 48824

Ronald E. Keeney, MD, Parke-Davis Co., Ann Arbor 48105

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(Continued on Page 166)

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References: 1. Martin, E.W., et al., ed.: Hazards of Medication, Philadelphia, J.B. Lippincott Co., 1971, p. 511. **2.** Seegmiller, J.E.: Med. Clin. North Amer. 45:1259-1272 (Sept.) 1961.

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John G. Lyday, MD, 1215 E. Michigan, Lansing 48912

Michael McAlvey, MD, Sparrow Hospital, Lansing 48912

Donald B. Muenk, MD, Harper Hospital, Detroit 48201

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Robert D. Steele, Jr., MD, 880 Woodward Ave. #105, Pontiac 48053

Pramote Tanswai, MD, 2321 Somerset Blvd., #206, Troy 48084

Dhiti Tepkasetkul, MD, 1510 Anthony St., Hancock 49930

Harvey B. Tonken, MD, Alpena General Hosp., Alpena 49707

N. S. Tyagi, MD, 819 Woodward Ave., Pontiac 48053

Otonas Vaitas, MD, 23122 Orchard Lake Rd. #200, Farmington 48024

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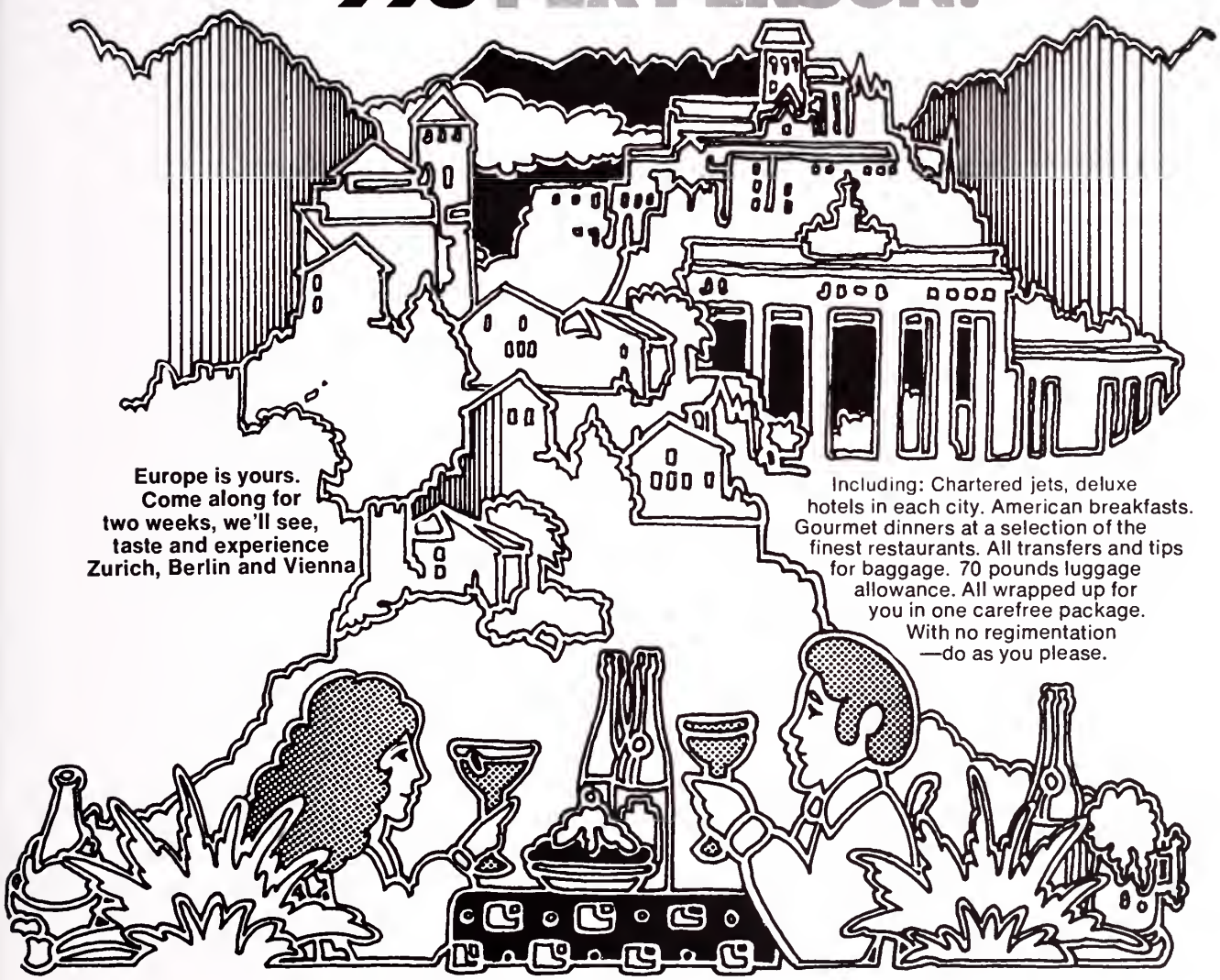
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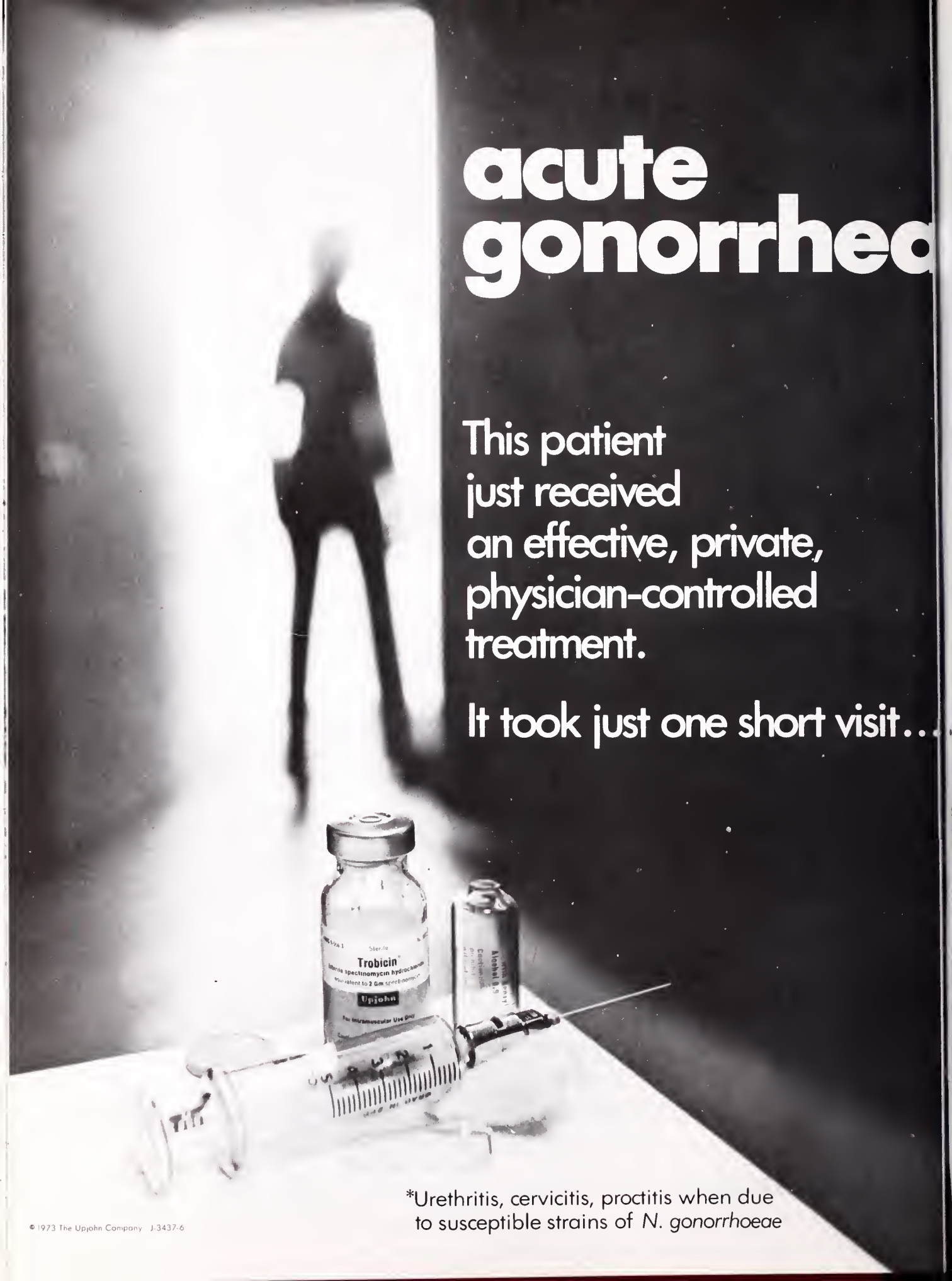

*Urethritis, cervicitis, proctitis when due to susceptible strains of *N. gonorrhoeae*

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Spectinomycin is indicated only for use in acute urethritis and proctitis in the male and acute cervicitis and/or proctitis in the female when due to susceptible strains of *N. gonorrhoeae*. The usual dosage for Trobicin in adult males is 2 grams intramuscularly†; 4 grams intramuscularly in females.

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Trobicin is not effective for any stage of syphilis. Trobicin may mask or delay the symptoms of incubating syphilis. If concurrent syphilis is suspected, follow the patient serologically for at least 3 months. Patients with syphilis should receive adequate specific anti-syphilitic therapy with an appropriate antibiotic.
Trobicin is contraindicated in patients previously found hypersensitive to it.

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Indications: Acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

Contraindications: Contraindicated in patients previously found hypersensitive to spectinomycin.

Warnings: Not indicated for the treatment of syphilis. Antibiotics used to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Patients should be carefully examined and monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected.
Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions should be observed with atopic individuals.
Clinical effectiveness should be monitored to detect evidence of development of resistance by *N. gonorrhoeae*.

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single- and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25° C and use within 24 hours after reconstitution with diluent.

Male—Inject 5 ml intramuscularly for a 2 gram dose. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.

Female—Inject 10 ml intramuscularly for a 4 gram dose.

How supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of 400 mg spectinomycin per ml (as the hydrochloride). For intramuscular use only.
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† For patients with gonorrheal proctitis and for patients in geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams is preferred.

school conducting the research must report annually to the legislature. Ohio allows the investigation of acupuncture only when conducted by a doctor of medicine or a doctor of osteopathic medicine licensed by the Ohio State Medical Board and requires all subjects receiving acupuncture to give informed consent.

Nevada reportedly permits unregulated practice of acupuncture.

Nationally, the AMA says that acupuncture, still an experimental procedure, should be done only by a licensed physician or dentist, or under his direct supervision." The Food and Drug Administration has ruled that all acupuncture paraphernalia must carry the following statement: "Caution: Experimental device limited to investigational use by or under the direct supervision of licensed medical or dental practitioners. This device is to be used only under conditions designed to protect the patient as a research subject and where the scientific protocol for investigation has been reviewed and approved by an appropriate institutional review committee or where conditions for such use are in accordance with state law."

The MSMS Council has requested "an appropriate committee at MSMS draft a white paper on acupuncture for broad distribution within and outside of State government."

The Council will review the draft at its March meeting.

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In Memoriam

August F. Bliesmer, MD
St. Joseph

August F. Bliesmer, MD, of St. Joseph, a surgeon in St. Joseph and Benton Harbor for 38 years prior to his retirement in 1972, died Feb. 22 at the age of 70.

Doctor Bliesmer was born in New Buffalo and was graduated from the University of Michigan Medical School in 1929. His postgraduate medical education was at University Hospital, Ann Arbor, and St. Luke's Hospital in Chicago. A fellow of the American College of Surgeons, Doctor Bliesmer was a past president of the Berrien County Medical Society and served for four years on the MSMS Committee on Public Relations.

Doctor Bliesmer served for eight years, seven as president, on the St. Joseph board of education and five years on the first board of trustees of Lake Michigan College. He also had been a member of the board of directors of the Michigan Association of School Boards.

Jose Guerrero, MD
Detroit

Jose Guerrero, MD, 80, of Detroit, died Feb. 3. A native of Nicaragua, Doctor Guerrero had practiced as a family physician in the Detroit area for more than 50 years. He was graduated from the University of Michigan Medical School in 1918.

Clyde K. Hasley, MD

Clyde K. Hasley, MD, 81, of Detroit, radiologist and medical educator and a life member of MSMS, died Jan. 27.

Doctor Hasley had served on the faculties of both the University of Michigan Medical School, where he received the MD degree in 1918, and the Wayne State University School of Medicine. He was a fellow of the American College of Radiology and belonged to the American Roentgen Ray Society, the Radiological Society of North America, the American Academy of Dermatology, the Inter-American College of Radiology and the Detroit Academy of Medicine. He served for nine years as a member of the board of directors of Michigan Medical Service and as a member of the MSMS House of Delegates.

Doctor Hasley was affiliated with Children's Hospital of Michigan and Grace Hospital and had published numerous papers and articles.

Carl H. Schulte, MD
Birmingham

Carl H. Schulte, MD, of Birmingham, retired chief medical officer of the Detroit Fire Department, died Feb. 13 at the age of 79. Doctor Schulte had practiced as a family physician with a special interest in industrial medicine for more than 50 years and in 1965 was granted life membership in MSMS.

Doctor Schulte was graduated from the Wayne State University School of Medicine in 1921 and was on the staff of Grace Hospital.

Enos G. Walker, MD
Lakeland

Enos G. Walker, MD, 75, a past president of the Livingston County Medical Society, died Jan. 20 at his home in Lakeland. Doctor Walker had belonged to the American Academy of Family Physicians for 30 years and in 1973 was made a charter fellow of the academy. He practiced in the Detroit area for 25 years prior to establishing his practice in Lakeland in 1950. He was a member of the senior medical staff of MacPherson Community Hospital in Howell.

Doctor Walker was graduated from the Eclectic Medical College in Cincinnati. He served with the army in Iceland, England and France prior to retiring with the reserve rank of colonel in 1959. He was president of the Livingston County Medical Society in 1957 and again in 1963.

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Medicine Sports Conference to Look at Knee Injuries

A report on a Peoria (Ill.) study of knee injuries among high school football players will be a highlight of the 1974 Michigan Conference on the Medical Aspects of Organized Athletics. The all-day conference, for physicians, coaches, trainers, principals and other interested persons, will be held April 11 on the campus of Grand Valley State Colleges at Allendale, west of Grand Rapids.

Bernard R. Cahill, MD, of Peoria, chairman of the Department of Orthopedics and Sports Medicine at the Peoria School of Medicine, will report on the knee study and also discuss chronic orthopedic problems in young athletes.

Gerald A. O'Connor, MD, University of Michigan team physician and conference co-chairman, will speak on "Internal Derangements of the Knee Joint — Diagnostic Clues."

Other speakers and their topics will include:

Lindsy McLean, head trainer, U-M athletic department, "The High School Training Program — Equipment and Standards;" James S. Feurig, MD, Michigan State University team physician, "The Psychology of Coaching;" Floyd Westendorp, MD, of Grand Rapids, MSU associate professor of psychiatry, "The Athlete-Coach Interaction," and Theodore J. Rupp, MD, of Grand Rapids, MSU assistant clinical professor of medicine, "Skin Problems in the Athlete."

Also taking part in the program will be Tom M. Johnson, MD, of Grand Rapids, assistant dean for the MSU College of Human Medicine Grand Rapids campus and Grand Valley State team physician, co-chairman with Doctor O'Connor, and Robert H. Evans, MD, of Sturgis, chairman of the MSMS Committee on Medical Aspects of Organized Athletics.

Information on conference registration is available from MSMS Headquarters.

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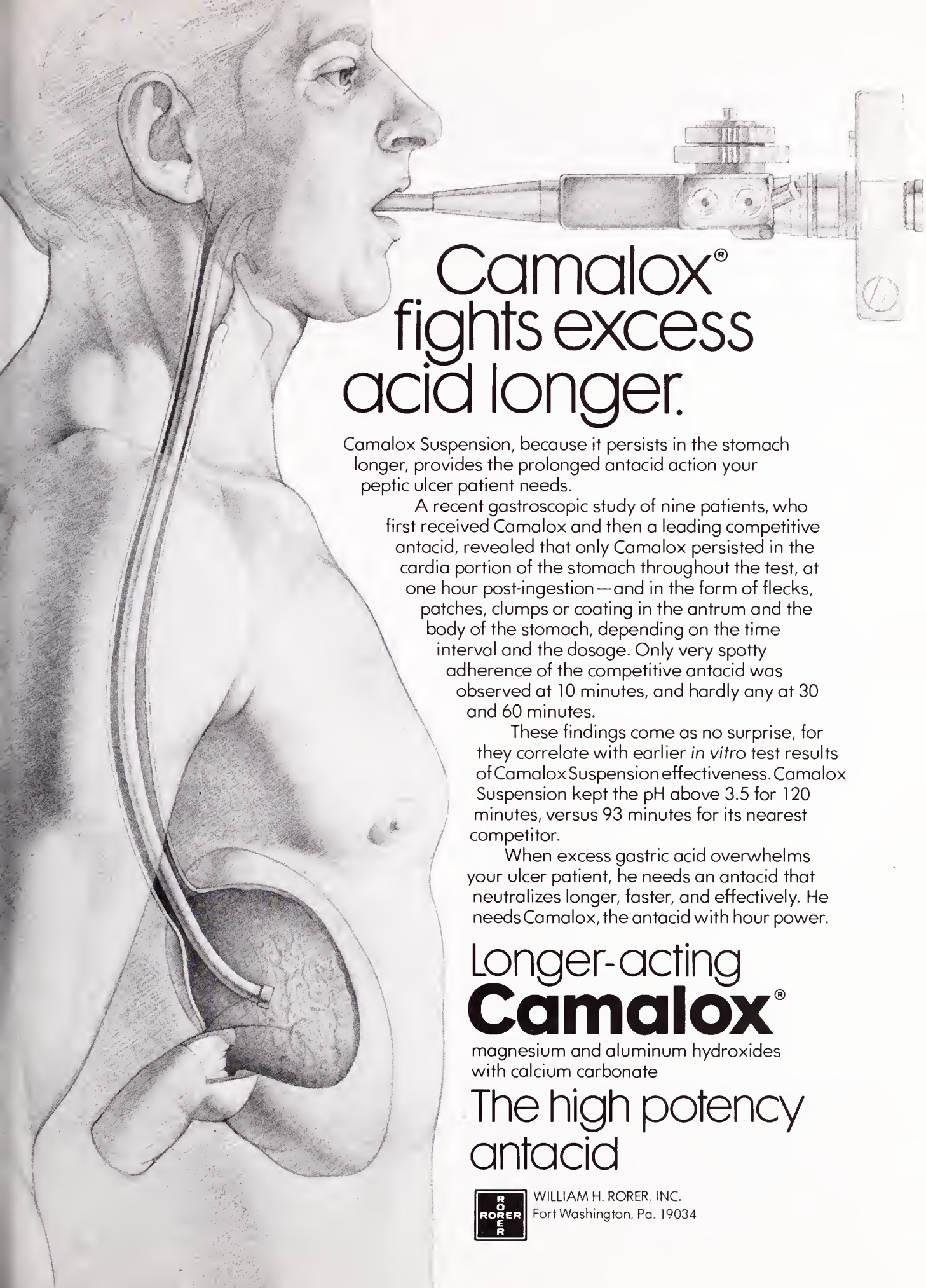

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WANTED: STUDENT HEALTH PHYSICIANS. Northern Michigan University, Marquette, Michigan 49855. Progressive Health Center serving 7500 students located in Michigans Upper Peninsula on the beautiful south shore of Lake Superior. Salary negotiable depending on training and experience. Minimum $25,000. Excellent fringe benefits. Contact: Robert B. White, M.D., University Health Center. An Equal Opportunity employer.

WANTED—Internist, Urologist, Ophthalmologist, Pediatrician and Family Practitioner for new 12 man Clinic in Iron Mountain, Michigan. The $500,000 Clinic Building will be completed in June of 74. Modern 120 bed hospital, with 3 million dollar expansion project in progress. Emergency Physicians group covers the hospital emergency room. Contact: R. L. Anderson, M.D. Dickinson County Memorial Hospital, Iron Mountain, Michigan 49801.

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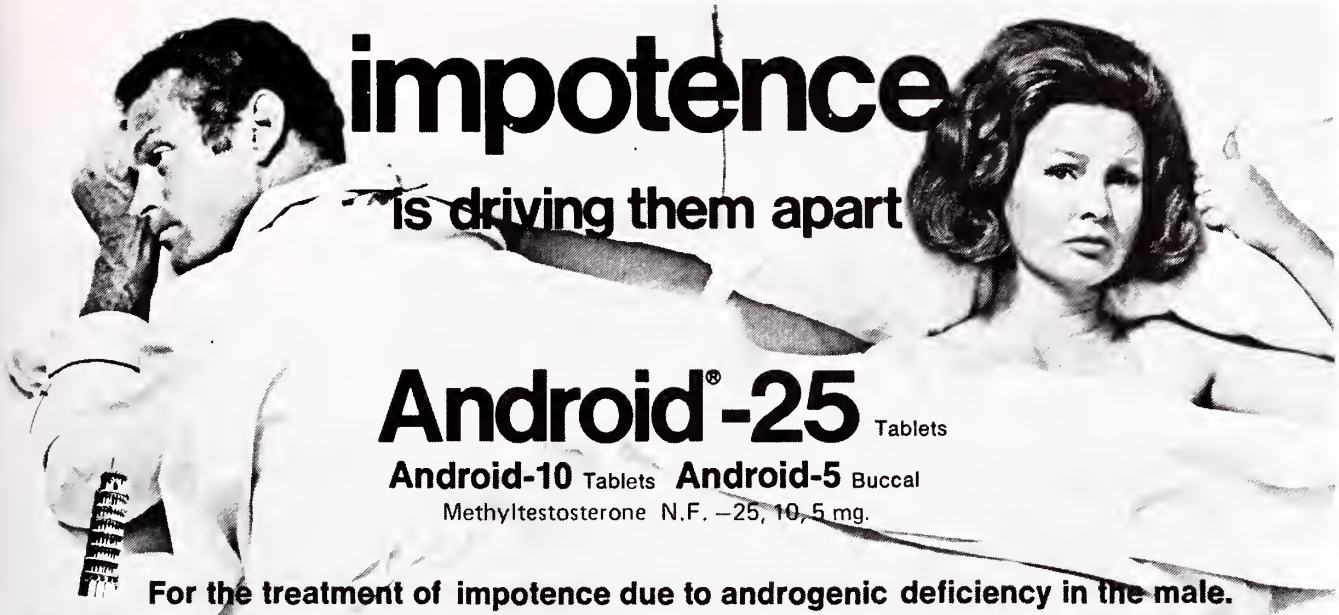
FAMILY PHYSICIAN—EDUCATION—position available in community educational program for a physician interested in developing and coordinating a family medicine educational experience for medical students. Faculty position with Michigan State University College of Human Medicine. For more information contact: Tom Johnson, M.D., or John P. Newton, M.D., Grand Rapids Area Medical Education Center, 220 Cherry Street, S.E., Grand Rapids, Michigan 49503. Phone (616) 459-1251.



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Beating the Deadline

By Herbert A. Auer, Executive Editor

Who says young men from small towns never go back home to practice medicine? **Roger Fitzpatrick, MD,** who was graduated in 1957 from high school at St. Johns, north of Lansing, has returned there to practice.

The Wayne County Medical Society recognized its past presidents at its recent annual meeting. Special guest was the WCMS president from 1925. That's almost 50 years ago! A rising salute was paid to **William J. Stapleton, MD,** president in 1925 who is now 97 years young.

It was not easy for Mush Ke Ke Anena, of the Peshoba Tribe of Indians, to leave the Leelanau Peninsula for Detroit. But **Dwight Schroeder, MD,** who was made an honorary tribal brother by the Peshoba in recognition of his outstanding medical and community service for 14 years at Northport, did move to become associate professor in family medicine at Wayne State University. Doctor Schroeder is a WSU medical school grad, class of 1957. He plans frequent visits to Northport.

The Saginaw County Medical Society Bulletin last month observed its 25th anniversary . . . and the first editor, **R. D. Mudd, MD,** is still a regular contributor. Doctor Mudd served as editor for the first six years and continues today as the associate editor. The current editor is **John E. Finger, MD,** the SCMS president.

For the fifth year, **Vivian M. Lewis, MD,** of Flint, has given students at the Kennedy School in Flint complete examinations as a public service. Doctor Lewis, a pediatrician, also is a member of the Flint Civil Rights Commission.

The first speech about quackery and chiropractic ever arranged by MSMS was given recently before the Ottawa County Medical Society by **Richard Gascoigne, MD,** of Adrian, chairman of the MSMS task force on chiropractic. His second address, given even more recently, was before the Kent County Medical Society.

The Westphalia Jaycettes convinced local businessmen to purchase a home and provide it rent free for a year as an incentive to bring **Taweesukoi Chuntarasupt, MD,** to the Clinton County community. Doctor Chuntarasupt is a native of Thailand.

It was appropriate that the first state governmental group to ban smoking at its meetings was the Michigan Air Pollution Commission. The commission recently adopted a resolution presented by **Richard Rasmussen, MD,** Grand Rapids, a member of the commission and one of the leaders in the MSMS stop-smoking efforts.

Citing his many contributions to crippled children and his many patients, the Michigan House and Senate, in a concurrent resolution, lauded **Richard C. Deming, MD,** of Jackson, as "a concerned and socially involved individual." He recently received the National Easter Seal Society for Crippled Children and Adults "Outstanding Achievement Award for Michigan" as well as the salute from lawmakers.

The Michigan State University Museum recently sent a truck to Central Lake, south of Charlevoix, to pick up an old examining chair and x-ray equipment used there by **Donald Duffie, MD,** who died in 1964. MSMS had suggested to the doctor's daughter, Virginia Duffie Steinweg, that MSU would appreciate having the equipment. Doctor Duffie began his practice in the Central Lake area in 1923.

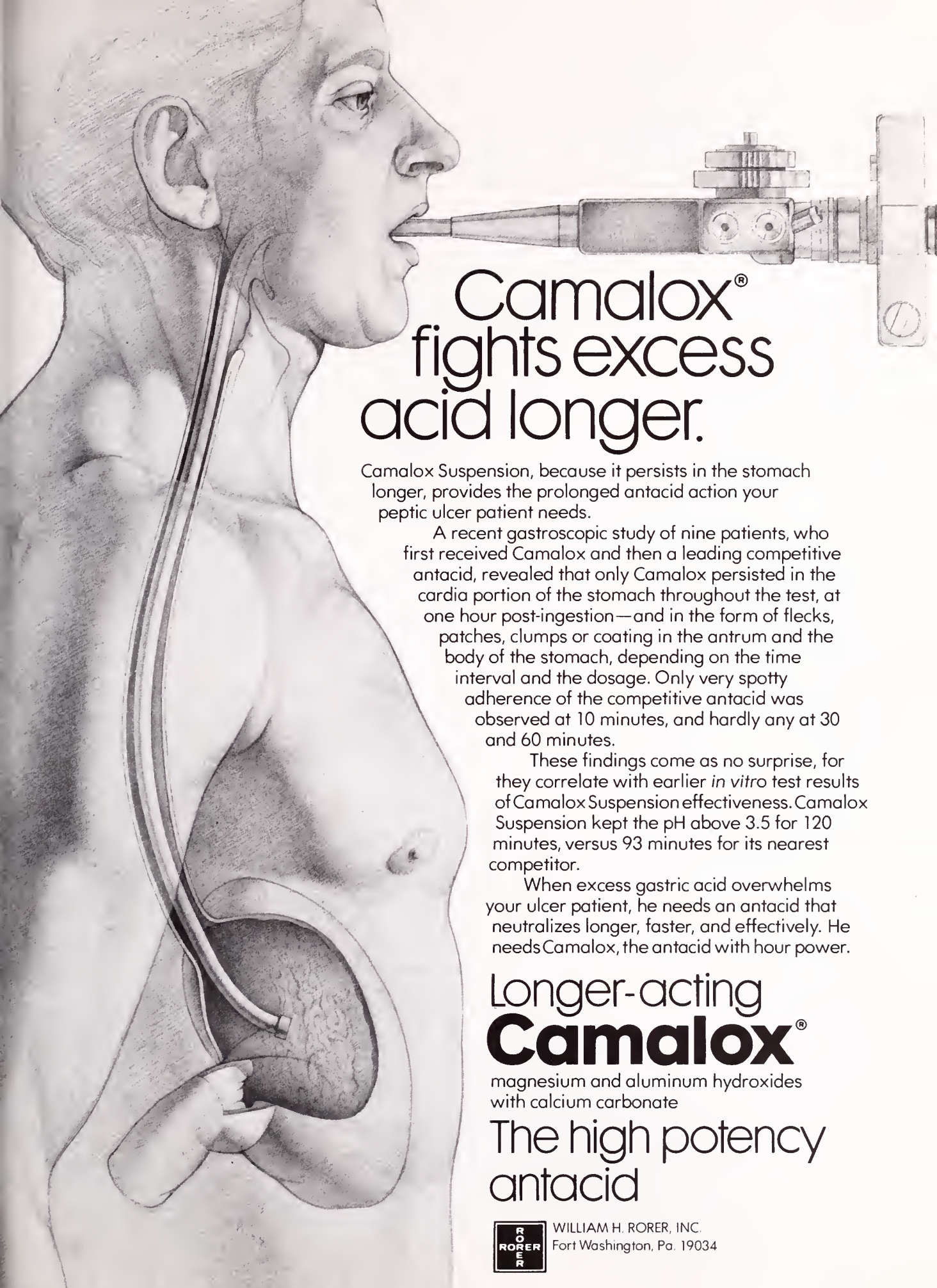
Dr. Gascoigne

Dr. Lewis

Dr. Stapleton

Dr. Mudd

This page will appear each month with news items "on the human side" gathered from correspondence, meetings, conversations and tips we hope you will send in from time to time.



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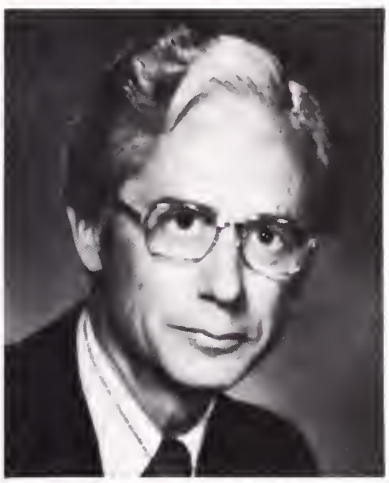
President's Page



Doctor Masters

Michigan State Medical Society and the Michigan Bar

There is one certainty this April 1974: every practicing physician is vitally concerned about the rising threat of malpractice action and/or the concomitant sky-rocketing premium rates. When the annual cost soars to $8,000, $10,000 and $12,000, as it has for selected specialties in Michigan, and is reported at $20,000 in California, rubric of good medical practice is unquestionably threatened.

Doctors seem to have a certain air of resignation about the whole matter, a feeling, perhaps, that "nothing can be done." But this must not be so. There is too much at stake!

Against this background, the leaders of MSMS have been meeting with the leaders of the Michigan Bar to explore matters of mutual concern. We find there are many. Three joint task forces are now at work to study (1) medical liability (2) medical records and (3) interprofessional relations.

In addition, we were invited to speak to the representative assembly of the State Bar in Detroit recently. Realizing that both professions have much to give, we asked the bar for help in the following areas of the malpractice situation:

1. Does Michigan need a statute of limitations to prohibit professional liability suits after a specified number of years? Presently suits often are started many years after the medical care was given.

2. Should Michigan's malpractice laws be recodified or rewritten? A foundation grant could be sought to support work on such a project at a law school.

3. Could screening committees of lawyers, doctors and public representatives review alleged malpractice charges before cases went to court?

4. Should plaintiffs' attorneys be required to post a good-faith-bond as is the case in California?

5. Compulsory arbitration might be a useful tool for lawyers and doctors alike, if we can get the malpractice insurance companies interested.

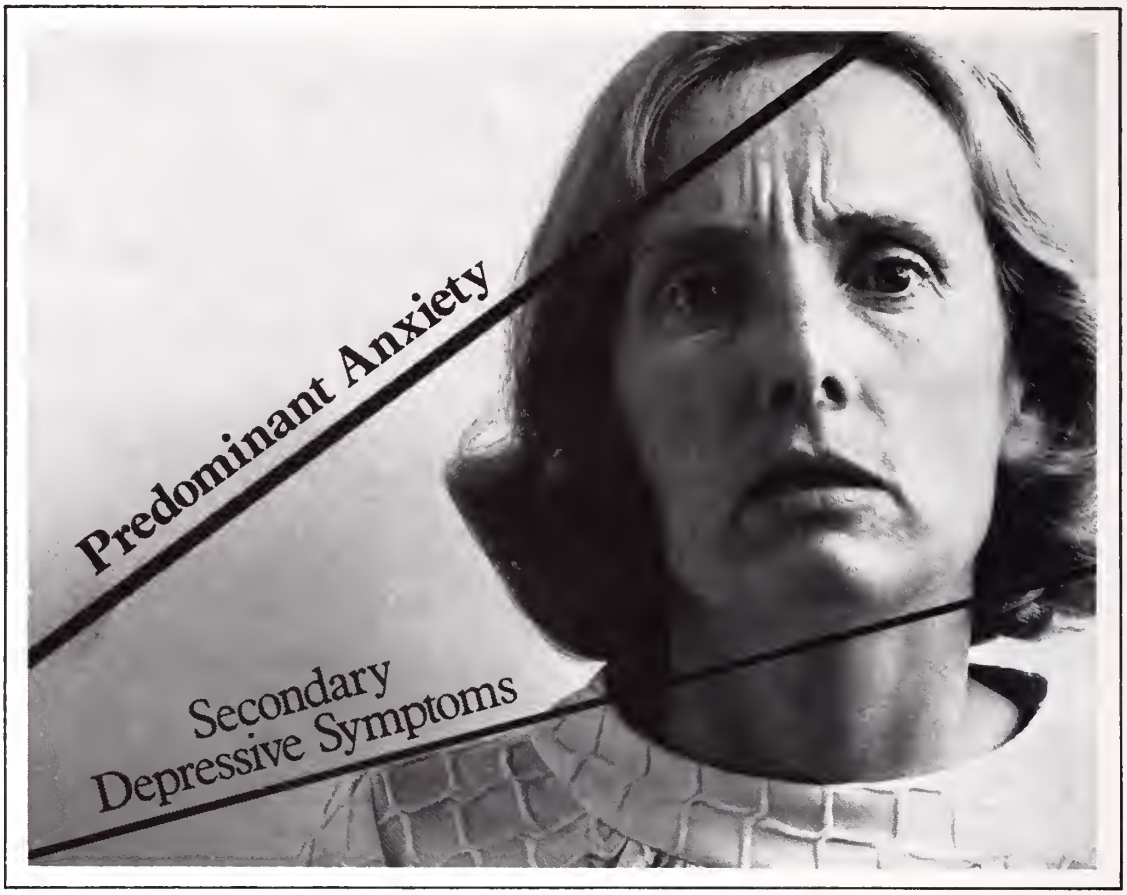
6. A solution should be sought to problems arising under the "breach of oral contract to heal" concept.

These seem to be practical lines of attack on the malpractice problem. The medical profession needs to address itself to its own problems as well. We must expand peer review operations and increase continuing medical education programs.

To go along with our own efforts, it is encouraging to note the definite desire for cooperation expressed by the Michigan Bar.

The "solution" to malpractice problems will not come as a magic national umbrella, but only by a series of positive constructive approaches on a state level. We welcome the partnership of the State Bar of Michigan.

Brooker L. Masters, MD



This psychoneurotic often responds

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

When you determine that the depressive symptoms are associated with or secondary to predominant anxiety in the psychoneurotic patient, consider Valium (diazepam) in addition to reassurance and counseling, for the psychotherapeutic support it provides. As anxiety is relieved, the depressive symptoms referable to it are also often relieved or reduced.

The beneficial effect of Valium is usually pronounced and rapid. Improvement generally becomes evident within a few days, although some patients may require a longer period. Moreover, Valium (diazepam) is generally well tolerated. Side effects most commonly reported are drowsiness, ataxia and fatigue. Caution your patients against engaging in hazardous occupations or driving.

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Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Letters

Permanente Medical Group Replies to Kenneth Ray, MD

Dear Doctor Ray:

Your editorial entitled "Integrity Is a Rare Commodity" in the Jan. 14, 1974, issued of *Detroit Medical News* (reprinted as a Commentary article. *Michigan Medicine* **73:** 85, February, 1974) is a matter of concern to the Permanente Medical Group physicians associated with the Kaiser Foundation Health Plan in Northern California.

Your editorial was written with certain information from a Doctor Robert Raskind at hand. In order for you to have made a balanced and thoughtful presentation in your editorial there was a large body of additional information, particularly about Doctor Raskind, which would have been useful for you.

Doctor Raskind left our partnership on the insistence of the Medical Group, not voluntarily because he objected to certain restrictions on his practice, as his letter to you may have implied. None of his professional colleagues in the group raised an objection to his termination. His credibility, which you accepted unquestioningly, was at a low level with the physicians in our group, both those primarily in clinical practice and those primarily in administration.

We do not ask you to accept the statements in this letter to you without your personal verification. We offer, therefore, a round trip, at our expense, to the San Francisco Bay Area so that you may meet and confer with our physicians, including the physician-in-chief most concerned with Doctor Raskind's professional activities, and the chief of our neurological surgery service. In addition, we would like to have you take time to talk with the chairmen of the Departments of Neurological Surgery at both Stanford Medical School and the University of California at San Francisco Medical School. You may wish to meet and talk with practicing neurosurgeons in the community who had professional contact with Doctor Raskind and know something of his practice.

You may wish to write to Doctor Henry Hood, chief of staff of Geisinger Health Center in Danville, Pa. Doctor Hood, in his role as Chairman of the Accreditation Commission of the American Association of Medical Clinics, inspected our medical office clinics during December, 1973. Doctor Hood is a neurosurgeon and evaluated our current practice.

Needless to say, we feel that a great deal of your editorial was inaccurate and was based on incomplete information. The Kaiser-Permanente Medical Care Program has been described and discussed in detail by persons not associated with our program. This information is all available to you. It includes the Larson Commission Report (AMA), a report for the California State Employees Retirement Plan (Doctor Malcolm Watts, California Medical Association), the Health Manpower Commission Report and many other reports.

We believe that fairness to the medical profession by its leaders includes the presentation of material which is objective, factual and accurate. We request that you take advantage of our offer to see for yourself. We are certain that, given the facts, you will repudiate most, if not all, of the statements set forth in your editorial. We trust that your sense of fairness and objectivity will cause you to accept our offer.

Sincerely yours,

John G. Smillie, MD
Assistant to the Executive Director
The Permanente Medical Group
Oakland, Calif.

MD Comments on TV Documentary About Abortion

To the Editor:

On the evening of Feb. 12, I watched a very fascinating documentary on the progress of abortion in the state of Michigan. As you know, this procedure is approved by MSMS, the state health department, U.S. Supreme Court, etc., etc., etc. . .

In your next issue, you should repeat Doctor Charles Berger's comment which was published in your March, 1973, issue: "I have insisted on the right of all citizens to act in consonance with their individual consciences and personal standards of morality." (*Michigan Medicine* **72:** 238)

Based on these standards, TV 2 News has now shown how medical clinics in Detroit do "abortions" on non-pregnant women. Certainly, it must fit their "personal" standards of morality.

It would be nice to know if these "services" are paid by Blue Cross or by Medicaid. When I retire, I think it will be a very safe way to tap into the treasury of both organizations.

Sincerely yours,
E. J. Dranginis, MD
Tecumseh

(Continued on Page 217)

Must vasodilators and therapy for other diseases come into conflict?

not if the vasodilator is

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the compatible vasodilator... no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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Stones of Madness

By James G. Ravin, MD; Gerald P. Hodge, BFA, and John J. Hartman, PhD, Ann Arbor

Mental illness has been treated by surgical techniques as varied as trephination in prehistoric times and frontal lobotomy, cingulotomy, thalamotomy, and amygdalotomy in this century. Prehistoric surgeons trephined skulls, presumably to release the demonic powers that were inside. Trephination was continued into the Middle Ages, and was described by Rogerius Salernitanus in his *Chirurgia* about 1170 A.D.:

"For mania or melancholia incise the top of the head in the shape of a cross, and perforate the cranium so as to expel the noxious matter. The patient is to be held in chains."[1]

More timid ancient physicians would concoct potions of the hellebore plant for their patients or would tie peony about their necks. During the 15th to 17th centuries charlatans roved across Europe incising wounds, couching cataracts, pulling teeth, letting blood and repairing hernias. Customarily these healers would travel with a large retinue, entertain the populace and then dispense medicine or perform surgery.

Possibly the most fascinating procedure done by the intinerant surgeons was the extraction of the "stone of madness." The operation began with a superficial incision in the forehead or scalp, conveniently where the patient could not view what was happening. Fortunately for the patient, trephination was not done. The surgeon kept a supply of "madness" stones nearby and would quickly produce one or more of them by sleight of hand. The stone was occasionally dropped into a metal container so that the sound would impress the patient. Many fine works of art depict this procedure of excision. They all are by Flemish and

Figure 1: "The Extraction of the Stone of Madness" by Hieronymus Bosch (c. 1450 — c. 1516), Prado, Madrid.

(Continued)

Doctor Ravin is a resident in ophthalmology, University of Michigan; Mr. Hodge is professor and director of medical and biological illustration and professor of art at the University of Michigan, and Doctor Hartman is assistant professor of psychiatry, University of Michigan, Ann Arbor.

Scientific Articles

Figure 2: "The Surgeon" by Jan Sanders van Hemessen (c. 1500 — c. 1566), Prado, Madrid.

Dutch artists of the 15th to 17th centuries. Why this theme was restricted to the Lowlands is not known, but it may be related to the popular love of pictures of everyday life *(genre scenes)* in the Lowlands, while religious art was more common in other parts of Europe. Works showing the stone extraction have been attributed to such famous artists as Hieronymus Bosch, Peter Breughel the Elder, Jan Steen, Frans Hals the Younger, Jan Sanders van Hemessen, David Teniers and Adriaen Brower.[2]

One of the best known of these works is "The Extraction of the Stone of Madness" *(Figure 1),* attributed to Hieronymus Bosch *(c. 1450—c. 1516).* Bosch's fantastic and weird paintings are very popular today due to his technical skill and unique, often uninterpretable subject matter. The surgeon seen here has a funnel inverted on his head like a dunce's cap and is wearing the long robe characteristic of medieval surgeons. A nun stands by with a Bible atop her head, probably representing her ignorance of its contents. She is staring idly off into the distance, playing the role of an unconcerned surgical assistant. A monk is holding a jug that contains the sole anesthetic, an alcoholic beverage. In the background landscape are a torture wheel and gallows, symbolic of the pain of the world. The inscription around the painting reads "Meester suijt die Keye ras, Myne name is Lubbert Das," which translates as "Master remove this stone quickly, my name is Lubbert Das."[3] Lubbert was a fool's name then, similar to

Figure 3: "Operation for Stones in the Head" by H. Weydmans (early 17th century), Philadelphia Museum of Art.

Figure 4: "Comt Mannen en Vroumen alle bey, en Laet u Snyden van de Key" by Carel Allard (1648 — c. 1709), present location unknown.

present usage of the word lummox. Close inspection of the object being removed from Lubbert's head and the objects on the table reveals that these are flowers, probably tulips. Flowers were thieves' jargon for money at that time,[4] implying that the surgeon was stealing from the patient. The nun's red, heart-shaped purse may be a depiction of the Flemish proberb "His heart is where his money is," implying that this surgical team had money as its primary goal. Many attempts have been made to interpret the paintings of Hieronymus Bosch. Psychiatrists and psychologists have found evidence for oral, anal and phallic fantasies in his paintings and primary process thinking may be prominent.[5-7] They claim Bosch expressed many of the ideas that are now fundamentals of psychoanalytic thinking, four centuries before Freud. "The Extraction of the Stone of Madness" is far less fantastic than most of Bosch's works and leaves little room for extensive psychoanalysis.

"The Surgeon" *(Figure 2)* by Jan Sanders van Hemessen *(c. 1500—c. 1566)* is set in a public marketplace. The patient's father agitatedly wrings his hands in prayer; his mother and sister, on the contrary, are calmly assisting with the operation. The H. Weydmans' engraving *(Figure 3)* done in the early seventeenth century is another fine example depicting stone extraction. The Flemish inscription amusingly translates "Come, come with great rejoicing; here the stones can be cut out of your wife."[8] "Come, men and women, come all, and have the stones removed from your head"[2] translates the inscription in *Figure 4.* This engraving is by Carel Allard *(1648—c. 1709),* a Dutch cartographer. Interestingly, Allard nearly lost his mapmaking license because he distributed "lewd and scurrilous" drawings at book fairs.[9] Most of his design is copied from an earlier engraving attributed to Peter Brueghel the Elder entitled "The Dean of Renais." The dean is the surgeon in the lower righthand corner using a huge pincers to remove a stone from a man's forehead. The caption under the dean reads in part, "I have never met a man or woman who did not have a stone in his body," indicating that he would be happy to extract stones *(and money)* from anyone. Many of the patients are shown to be insane by their foolish characterization, e.g., the monk being carried. The playing cards in his hat and the wooden spoon in his belt are traditional medieval attributes of a fool. An owl, symbolic of the darkness of the world that madmen inhabit, is in the center of the composition. Three figures are shown passing fecal stones. One unfortunate soul near the top of the

(Continued)

Figure 5: "The Physician Curing Fantasy" by unknown 17th century French artist, Philadelphia Museum of Art.

engraving is having a fecal stone removed with pincers identical to those used by the dean to remove the cerebral stones. Stones of the head and stones of the bowels are similarly engraved and extracted.

The idea that mental illness is caused by foreign bodies lodged in the head is old and widespread. When we say that someone has "rocks in his head" to indicate madness we are using the same metaphor. Psychologically speaking, the stone was probably chosen as the material responsible for madness as a symbol for feces. It is not unusual for rocks, stones and earth to represent anal concerns in dreams. Psychotic patients today often say that they are undergoing psychotherapy to "get the shit out of my head" *(personal observations, J.J.H)*. "Shithead" is a current appellation for someone who is confused and despised.[10] Support for this fecal hypothesis may be found in another seventeenth century engraving *(Figure 5)*, "The Physician Curing Fantasy." The French caption says, "The physician curing fantasy, also purging madness by drugs."[11] A variation of this engraving exists with a long German inscription that translates:

"You sick men and women: If you wish to entrust yourselves to a doctor, then entrust yourselves to me. I am the best healer of the human race . . . What trash was stuck in your head! You confused simpleton! You have me producing more rubbish from your head than there is in almost a whole forest of monkeys. If I make you free of this illness then proclaim that I am a master."[12]

Terms such as trash and rubbish are fecal connotations. Allard's engraving *(Figure 4)* shows several methods by which stones may be removed from the body. Stones are seen here as fecal equivalents in being removed by pincers from the anus and by flagellation of the buttocks. The idea that foreign substances can invade the brain to cause psychic distress is an example of the defense mechanism of externalization. This defense allows unwanted impulses or values to be attributed to an

(Continued on Page 201)

Perinatal Tips

By Paul M. Zavell, MD

The following case from the files of the Wayne County Medical Society Perinatal Mortality Study Committee is presented as an aid in continuing education.

Maternal

This was the second pregnancy for this 21-year-old O+ GII, P 1 (II) white mother. Her pregnancy through 37 weeks had been completely normal and she had had regular prenatal visits from the second month on. At 37 weeks she started to have slow but definite vaginal bleeding. When she called her obstetrician he admitted her immediately to the hospital. There examination revealed a tender right upper quadrant of the uterus and the diagnoses of "Marginal sinus rupture and/or abruptio placenta" were entertained. With bed rest the bleeding stopped but began anew when she got out of bed. After seven days in the hospital all bleeding seemed to have stopped. She was sent home but two days later bleeding recurred. She was readmitted to the hospital where with bed rest bleeding stopped. However, at this time the membranes were surgically ruptured and labor then started in earnest. Three hours, 7 minutes later a male infant was born. Marginal sinus rupture was then confirmed. HAI and VDRL were normal. The mother's post-natal course was completely uneventful.

Fetal

This 5 pound 5¼ ounce W.M.I. appeared normal at birth. Cord blood was A+, Coombs and ABO negative. The infant was started on breast feeding. For the first 24 hours all seemed well. At about 28 hours of age the infant was noted to be a little cyanotic with mild retraction and only "so-so sucking." Bruises of the upper back and chest wall were noted. He was put in 30% oxygen. Temp. was 99.6° R. By 52 hours of age retraction had increased slightly, the infant appeared slightly jaundiced and sucking seemed "poor." Temp. was still 96.6° R. Breast feeding was stopped and glucose water tid between Similac feedings were begun. Hgb was reported as 17.9 gm. For the next 36 hours the infant appeared more active and in no great distress. Oxygen was gradually lowered and sucking appeared improved. However by 90 hours of age jaundice seemed increased and he was more lethargic with onset of occasional apneic and cyanotic spells.

Studies done then showed total Bilirubin of 10.4 mgm % (9.9 mgm % Indirect), portable chest x-ray was normal, and PKU reported as negative. Because of the lethargy, cyanosis and poor sucking, the infant was transferred to N.I.C.U. There additionally it was noted that stimuli were needed to make the infant cry. The impressions were (1) Hyperbilirubenemia (? ABO incompatibility) and (2) R/O Sepsis. Orders included CBC, Bilirubin, chest x-ray and L.P. The baby was put in an isolette, mask O_2 with stimulation at times to make him breathe. He was very lethargic, very jaundiced and heart rate of 140/min. At 96 hours of age Kanomycin 25 mgm IM q 12 h and Aq. Penicillin 150,000 U IV q 12 h with an IV of 5% G/W in 0.2 NS were started. At this time the heart rate was 152 with respiratory rate of 32/minute. By 100 hours of age the infant was "jittery" and very hyperactive with marked abdominal distention. Urine at this time was very concentrated and scanty. Results from admission studies now were available. These were: Hgb of 11.1 gm, Hct of 35, WBC of 5200, PMN of 10, Bd of 7, Lymph of 70, Mono of 09, Eos of 02, Myelo of 02 with Normoblasts of 25/100 WBC, Bilirubin total of 10.5 mgm %, L.P. with 14,600 RBC, WBC of 20 (80% PMN, 20% Mono), Protein 310 and glucose of 5. Chest x-ray showed hyperinflated clear lung fields with heart and mediastinal structures normal and gas throughout the G.I. tract. In the next 12 hours the infant's condition steadily worsened with duskiness, apnea, vomiting of green secretions and

(Continued)

The author is a member, Neo-Natal and Hospital Care Committee, Michigan Chapter, American Academy of Pediatrics, and chairman, Perinatal Mortality Study Committee, Wayne County Medical Society

mucus, generalized edematous thickening of all the skin of the body, increasing jaundice and intermittent seizures. The infant expired at 113 hours of age following a generalized convulsion despite heroic efforts using Decadron, Phenobarbital, I.V. antibiotics and fluids.

A post mortem was done that revealed findings compatible with meningitis and a heavy growth of Hemolytic Beta Streptococcus in the L.P. culture obtained before birth was noted.

Perinatal Committee Comments

1. Admission of a pregnant mother with vaginal bleeding to the hospital as in this case was justified. However, with some doubt as to the true cause of the bleeding, the committee felt that bed rest alone as treatment was not sufficient. It felt some sort of investigative studies such as a placentogram or scan were in order if not at least a sterile vaginal exam under a double set-up in the operating room.
2. Findings of cyanosis, retraction and poor sucking should alert one to possible respiratory, cardiac or CNS difficulties. The addition of lethargy and increasing jaundice without detectable blood incompatibility should point in the direction also of infection (i.e. sepsis and/or meningitis).
3. A low W.B.C. (5200) in a newborn is not a normal finding. This could be indicative of a viral problem but just as frequently indicates a bacterial infection. If there is any question of reliability, the test should be quickly repeated and efforts to detect infection (blood, pharyngeal, L.P. culture) should be initiated.
4. A drop in hemoglobin of 6.8 gm as noted here in a relatively short period of time (about 60 hours) should alert one to possible internal bleeding (intracranially, subcapsular of liver or splenic bleeding, etc.). This is reinforced here with unexplained bruising on the body. In this particular case, however, the hemoglobin drop was attributed to rehydration of the infant.
5. Glucose of 5 from the C.S.F. after an L.P. should alert one to infection or hypoglycemia (or error of laboratory).
6. Whenever an infant begins to show signs and symptoms suggestive of infection (as here with lethargy, poor suck, cyanosis, respiratory distress, jaundice) cultures of CNS, blood, pharynx (others if indicated) should be obtained and antibiotics for possible sepsis or meningitis (such as penicillin and kantrex or penicillin and garamycin) should be started. There was too long of a delay here in initiation of antimicrobial therapy.
7. Diagnoses other than infection suggested by this case were hypoglycemia, possible internal bleeding (such as noted earlier), possible heart failure, and undetected blood incompatibility (ABO) despite ABO and Coombs tests.

Monthly Surveillance Report

Cases of Certain Diseases
Reported to the Michigan Department of Public Health
For the four-week period ending March 1, 1974

MICHIGAN DEPARTMENT OF PUBLIC HEALTH

	1974 This 4-Week Period	1973 Same 4-Week Period	1974 Total To Above Date	1973 Total Same Date	Total Cases for 1973
Rubella	128	176	274	267	2,001
Cong Rubella Syndrome	0	1	0	1	4
Measles	309	275	476	505	4,552
Whooping Cough	5	10	14	22	86
Diphtheria	0	0	0	0	0
Mumps	888	491	1,808	1,261	5,042
Scarlet Fever & Strep Sore Throat	5,482	2,189	9,730	4,647	24,467
Tetanus	0	0	1	0	2
Poliomyelitis (paralytic)	0	0	0	0	0
Hepatitis	304	308	717	693	3,872
Salmonellosis (other than S. typhi)	87	49	224	100	795
Typhoid Fever (S. typhi)	1	0	2	1	14
Shigellosis	117	25	210	97	623
Aseptic Meningitis	12	6	26	22	434
Encephalitis	2	8	4	19	163
Meningococcic Meningitis	4	6	8	7	54
H. Influenza Meningitis	12	7	27	14	89
Tuberculosis	74	77	206	256	1,380
Syphilis	328	411	642	775	4,328
Gonorrhea	2,469	2,202	5,626	4,965	31,128

Information can be supplied by the local health department on the local incidence of disease.

Maurice Reizen, MD, Director
Michigan Department of Public Health

Improved Survival in Refractory Endotoxin Shock with Heparin and Dextrose

By John L. Herlache, MD; James M. Winkler, MD, and Charles Gehrke, MD, Ann Arbor

Synopsis — Abstract

Endotoxic shock was induced in four groups of five dogs each who received 1) no treatment, 2) 5 per cent dextrose in lactated Ringers, 3) heparin, 4 mg/kg/24 hours plus lactated Ringers, or 4) heparin plus 5 per cent dextrose in lactated Ringers. Fluid administration began two hours after innoculation and continued for 8 hours or until termination. All animals received sufficient lactated Ringers solution to maintain the patency of arterial and venous catheters. Heparinization in Groups III and IV began one hour after endotoxin administration.

Vital signs, coagulation factors, blood gases, and glucose metabolism were measured for eight hours after treatment began. Dogs living longer than 24 hours after treatment were considered survivors.

Two mechanisms of death occurred in the untreated control group; obstruction of the microvascular tree (intravascular clotting which impaired delivery and utilization of oxygen and glucose) and hypoglycemia (a result of depleted endogenous glucose stores).

Treatment with dextrose alone did not improve survival, since it could not be delivered for metabolism. Treatment with heparin alone improved the delivery system, decreased metabolic acidosis and improved utilization of energy substrate. The endogenous glucose stores were not sufficient, however, to support the hypermetabolic state of endotoxic shock. Treatment with heparin plus dextrose improved survival by improving the delivery system by opening the microvascular tree and by preventing the resultant hypoglycemia.

Diffuse intravascular coagulation is a consistent finding in refractory endotoxin shock, causing an obstruction of the micro-vascular tree, rendering the patient unresponsive to usual medical therapy.[5] Coexistent with the development of the diffuse intravascular coagulation (DIC) is the development of an abnormal glucose metabolic pattern. Reversal of the DIC with heparin combined with administration of an energy substrate will be shown to improve survival.

Materials and Methods

Twenty female dogs, each weighing 15 to 19 kg. were starved for 24 hours prior to trial. They were then anesthetized intravenously with sodium thiamyl (Suratal). Central venous and arterial pressure catheters were placed in the internal jugular vein and common carotid artery. A Foley catheter was placed to dependent drainage, and the dogs were then positioned upright in a sling apparatus.

Mean arterial blood pressures, central venous pressures, and arterial blood gases were recorded for control values. Coagulation studies consisting of thrombin clotting time, fibrinogen assay, and platelet count were also determined.

Five mg. *E. Coli* endotoxin was administered intravenously, and vital signs, intake and output were monitored half-hourly. Coagulation studies and measurement of arterial blood gases and blood glucoses were made at one hour, three hours, six hours and eight hours after administration of the endotoxin. Dogs surviving longer than 24 hours after the eight hour trial period were considered survivors.

The dogs were divided into four groups of five dogs each.

Group I was the control group. No treatment was given. Lactated Ringers solution was given only in quantities necessary to maintain the patency of the arterial and venous catheters.

Group II dogs received five percent dextrose in lactated Ringers beginning two hours after the endotoxin was given. The amount was determined by the mean arterial blood pressure, central venous pressure and urinary output. The primary goal was to maintain the mean arterial blood pressure above 70 mm mercury.

(Continued)

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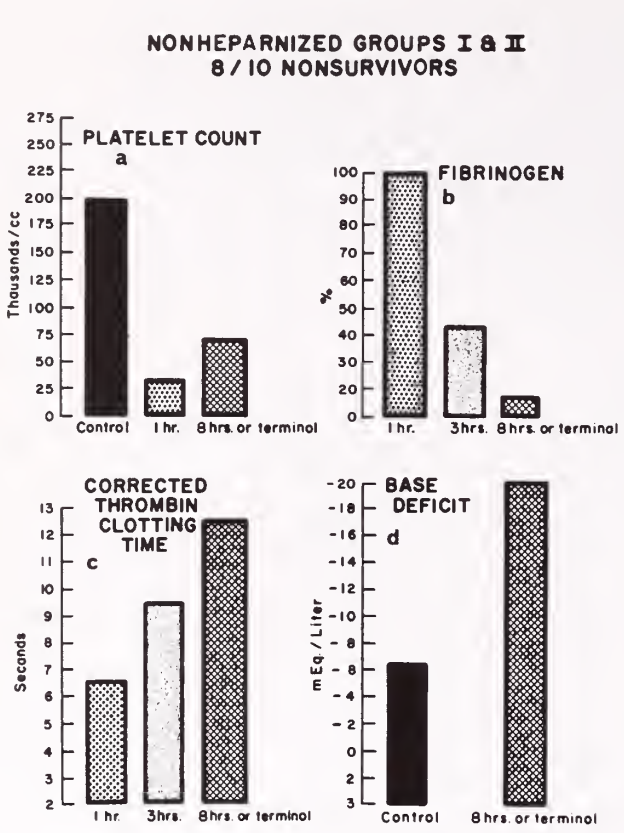

Figure 1: Coagulation Studies and Base Deficits — Groups I and II — Averages of the eight nonsurvivors.

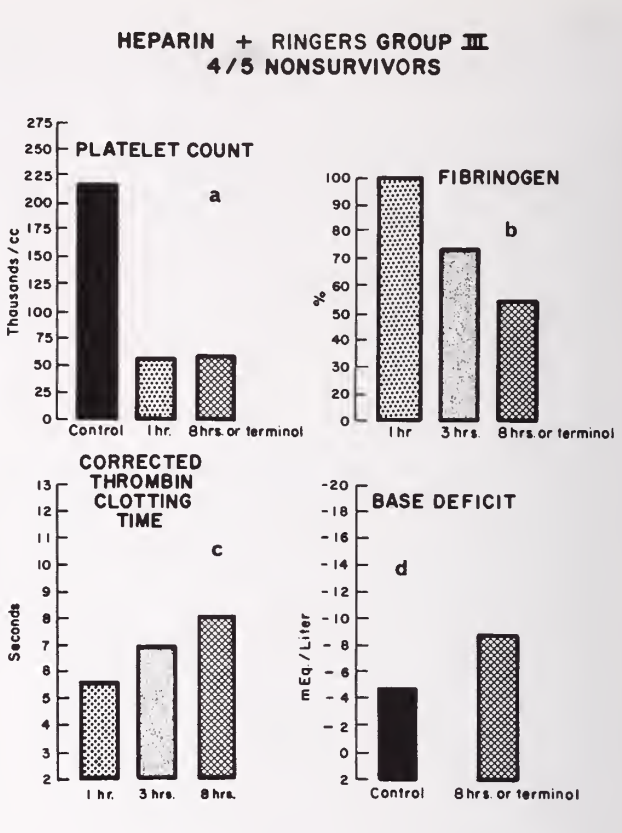

Figure 2: Coagulation Studies and Base Deficits — Group III — Averages of the four nonsurvivors.

Group III received heparin and lactated Ringers. Fluid was given in a manner similar to Group II. Heparin, four milligrams per kilogram per 24 hours, was given intravenously in equally divided hourly doses during the eight hour experimental period, beginning one hour after administration of the endotoxin. After completion of the eight hour experimental period, the heparin was given subcutaneously every eight hours in equally divided doses.

Group IV received combination therapy of heparin and five percent dextrose in lactated Ringers. These were given as in Groups II and III.

Results

One animal in each group demonstrated treatment responses which were markedly dissimilar to that of the rest of the group (one survivor each in Groups I, II and III responded similarly to Group IV dogs; the one Group IV nonsurvivor responded similarly to Group II dogs). All animals, however, were included in computation of the data.

The average amounts of fluid given over the eight-hour trial period were: Control Group I, 178 cc; Dextrose Group II, 3403 cc; Heparin Group III, 3480 cc; Heparin plus Dextrose Group IV, 1910 cc. The initial resuscitation between the second and third hour required 870 cc in the Dextrose Group II (mean, 43.5 g. dextrose) and 388 cc (mean, 19.4 g. dextrose) in the Heparin plus Dextrose Group IV. The amount of fluid required to maintain blood pressures above 70 mm. mercury after this period was also much less in the Heparin plus Dextrose Group IV, resulting in total dextrose values of 170 g/ dog in Group II, 95 g/ dog in Group IV. Because of this disparity, absolute values in the glucose metabolic patterns will vary, but it is the patterns rather than the absolute values which are presented here to demonstrate the ability or inability to utilize the energy substrate administered.

Total urinary outputs averaged 0.4 cc in Group I, 309 cc in Group II, 393 cc in Group III, and 561 cc in Group IV.

Results are shown graphically in Figures 1 to 4, according to group and time. Dogs in Groups I and II had similar coagulation studies and are considered together.

There was a marked fall in platelet count from an initial average of 200,000/cc to 26,000/cc after 1 hour in the first two groups. The levels at eight hours averaged 73,000/cc. This pattern was repeated in Group III dogs where platelet counts fell to 56,000 without significant recovery by eight hours or the time of death. Group IV animals

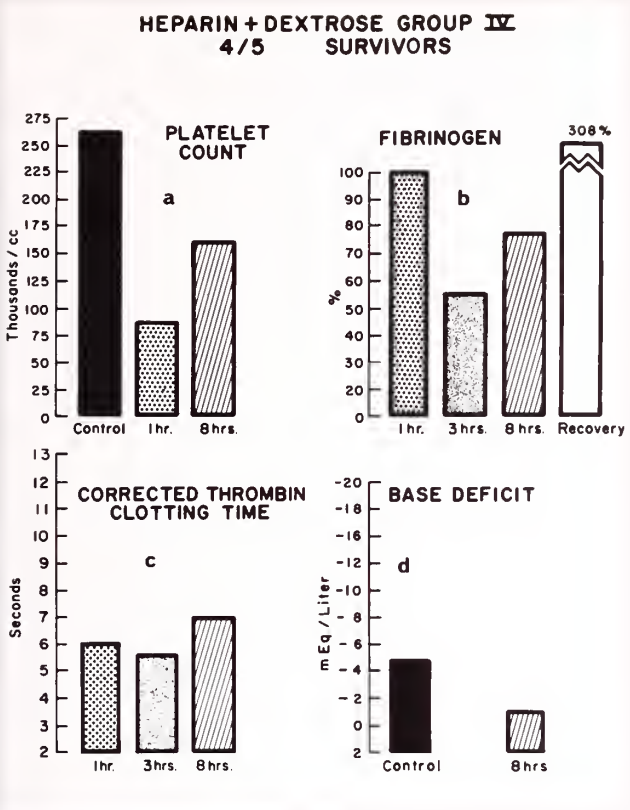

Figure 3: Coagulation Studies and Base Deficits — Group IV — Averages of the four survivors.

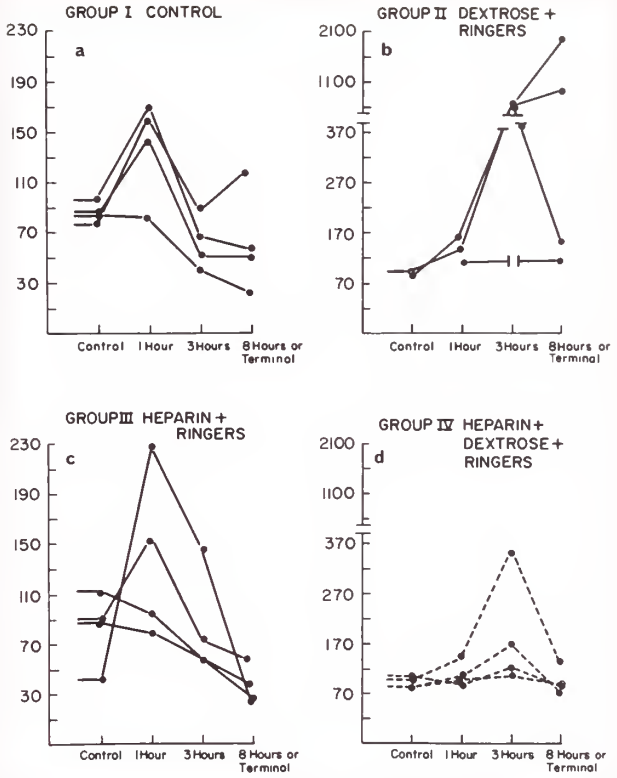

Figure 4: Blood Glucose Patterns of Groups I through IV.

showed the same early depression, but there was a recovery to 154,000/cc by eight hours.

Fibrinogen levels fell significantly in Groups I and II with an eight hour level of 18 per cent of the control value. There was also a progressive fall in fibrinogen levels of Group III animals throughout the trial period, but these dogs had final levels of 55 per cent of the control value, indicating less severity of DIC in this group than in the unheparinized groups. Levels in Group IV dogs improved even more substantially from 55 per cent of the control value after three hours to 78 per cent after eight hours.

Groups I and II had an average corrected thrombin clotting time of 12.4 seconds at eight hours or the time of death. Group III animals had considerably shorter times, averaging 8.0 seconds. Group IV animals demonstrated a reversal of DIC with protamine sulphate corrected thrombin clotting times which did not become prolonged throughout the eight hour trial period.

The coagulation study patterns were attended by similar patterns of metabolic acidosis. The average base deficit in Groups I and II was 20 meq/liter by eight hours or the time of death indicating impaired oxygen delivery. In Groups III and IV, however, there was an increase in aerobic metabolism as indicated by a base deficit of 8.7 meq/liter in Group III and fully sufficient delivery and utilization of oxygen in Group IV.

The varying degrees of acidosis were reflected in abnormal glucose patterns as illustrated in Figure 4. Group I control animals demonstrated a tendency for elevated glucose levels at one hour which fell to normal or below by three hours. Three dogs died with glucose levels of 57, 49, and 22 mg/100 ml., indicating that endogenous glucose was not present in sufficient supply to support the hypermetabolic state of endotoxic shock. One dog in Group I died with an elevated glucose level of 122 mg/100 ml. serum, indicating mobilization of endogenous glucose stores, but anaerobic metabolism of these stores. In Group II, where dextrose was given to evaluate this hypoglycemic effect, glucose levels of the nonsurviving dogs at one hour were similar to the controls. At three hours, following the burst of dextrose during the initial resuscitative efforts, levels were elevated rather than depressed. At eight hours, two dogs had extremely high levels of 930 and 1980 mg/100 ml. serum, indicating poor delivery to the cells with glucose accumulating in the peripheral circulation. The other two nonsurvivors had levels of 118 and 140 mg/100 ml. The marked metabolic acidosis of these animals suggests that oxygen delivery was impaired to the

(Continued)

point of causing anaerobic glucose metabolism.

Glucose utilization was much improved in Group III animals because of the decreased severity of DIC. Glucose patterns were similar to controls with elevations at one hour which fell by three hours. At eight hours or the time of death, glucose levels ranged from 18 to 56 mg/100 ml, indicating that glucose was being delivered and utilized. However, the survival rate remained at only 20 per cent. Similarly, Group IV animals showed elevated glucose levels at one hour and at three hours (103 to 360 mg/100 ml). However, by eight hours all glucose levels had fallen to a range of 70 to 127 mg/100 ml, indicating improved delivery to the cells with better utilization of the energy substrate as compared to Group II. With these improvements in coagulation factors, glucose metabolism, and acid-base balance, survival improved to 80 percent.

Discussion

The significance of diffuse intravascular coagulation is associated with the refractory and irreversible stages of shock.[5,12] In this study, the large amount of fluid requirement in Group II and III without improvement in survival established that shock, refractory to fluid administration alone, occurred by two hours after administration of the endotoxin.

Platelet and fibrinogen levels initially were depressed in all animals, establishing the consistent occurrence of a consumptive coagulopathy. The most marked early change was a fall in the platelet count. It has been shown by others that this occurs within the first 15 minutes after shock occurs.[12] This is the time of lowest blood pressure which permits stagnation and layering out of the blood elements, which in turn results in platelet agglutination, sequestration and breakdown, and initiates DIC.[4,12] However, this consumption was less pronounced in the heparinized dogs of Group III and was reversed in the heparin-plus-dextrose-treated-dogs of Group IV.

The fibrinogen assay and protamine-sulphate-corrected thrombin clotting times also demonstrated the progression of DIC in the four groups. There was less consumption of fibrinogen and shorter corrected clotting times in the heparinized groups than in the unheparinized groups, which indicates a reversal of DIC to a level at which fibrin split products were no longer detectable by the methods used.

The degree of metabolic acidosis in each group paralleled the degree of noncorrectability of the thrombin clotting times. This has also been observed in man,[7] and gives substantiating evidence that DIC is related to the development of anaerobic metabolism in refractory shock. The metabolic acidosis was considered to be the result of insufficient oxygen delivery to cells because of the obstructed microvascular tree.

Changes in glucose metabolic patterns were also seen as a result of DIC. Early rises in all groups can be explained by increased glycogenolysis in the liver, with corresponding inhibition of insulin release from the pancreas.[1-3,8-10,13] Three nonsurviving animals had markedly elevated glucose levels and higher metabolic acidosis than those levels in heparinized groups. This suggests that both oxygen and glucose metabolism were impaired, with accumulation of glucose in the peripheral circulation. Others have correlated irreversible shock with glycogen depletion in the liver resulting in hypoglycemia.[6,11] This was felt to be the mechanism of death in seven nonsurvivors which lacked sufficient endogenous stores. Heparin-plus-dextrose administration resulted in a reversal of DIC. There was no accumulation of glucose in the peripheral circulation and no base deficit in the survivors, which indicates that both glucose and oxygen delivery were adequate. Administration of the dextrose prevented hypoglycemia.

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Porcine Xenografts in the Treatment of Mitral Valvular Disease in Children

By Lorenzo Gonzalez-Lavin, MD; East Lansing, and Gordon M. Folger, MD, and Julio C. Davila, MD, Detroit

Mitral valvular defects in children, either of congenital or acquired origin, may cause such derangements in cardiac hemodynamics as to render the child completely disabled. While some lesions can be corrected by valvuloplasties,[1-4] others can be managed only by valve replacement.[5-8] Consequently, there has been an understandable hesitancy among some pediatricians and pediatric cardiologists to refer children with far advanced valvular heart disease for surgical treatment. The unsettled questions arising from the need for prolonged use of anticoagulants, the difficulty in providing a valve that will not require subsequent replacement as the child grows and the unknown long-term function of the early prosthetic valves have been cogent reasons for this attitude.

Improvements in prosthetic and biological valves[9-14,16] and recent encouraging reports on valvular replacement in children[17-20], justify a more aggressive approach to the management of valvular lesions in this specific group of patients. We have recently operated on two children in whom porcine xenograft valves were used. The report of these cases and a review of the pertinent literature are the purpose of this communication.

Case Reports

G.D. 129 83 47-6. This is an 11-year-old white boy, who in 1962 at the age of 3½ years had rheumatic fever for which he was hospitalized for over a month. During this period the diagnosis of mitral regurgitation was made. Despite prophylactic penicillin he continued to have repeated attacks of sore throats and he developed physical limitations.

G.D.

Table I

Cardiac Catheterization Case I

	3/11/70		9/31/72	
	Pressures MM.HG.	O_2 Sat. %	Pressures MM.HG.	O_2 Sat. %
SVC		85		65
IVC		85		67
RA	5	81	V=20	62
RV	40-5		65-4-11	58
MPA	36/15	74	69/34	61
LA				
LV	120-10		111/8-17	93
AO	120/90	94	113/82	92
PA Wedge	18	97		
Pulm. Art. Resistance			10.5 units	
Syst. Art. Resistance			32 units	
Cardiac Index			2.56	

In 1968 he had a recurrent attack of rheumatic fever and developed congestive heart failure. At this time he was treated with steroids and digitalis.

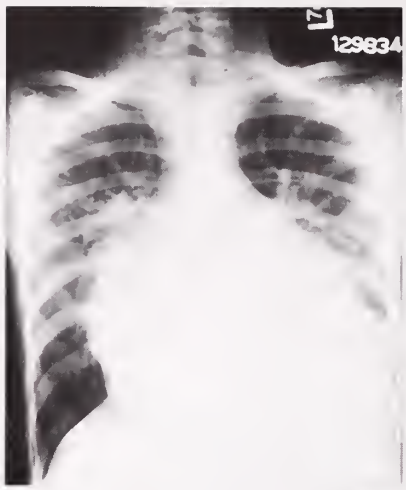
In 1970 he was admitted to Henry Ford Hospital for cardiac catheterization which revealed moderately severe mitral regurgitation and elevation of pressure in the pulmonary circulation. *(Table I)*

(Continued)

This paper is from the Divisions of Thoracic and Cardiac Surgery and Pediatric-Cardiology Henry Ford Hospital, Detroit.

Requests for reprints should be addressed to L. Gonzalez-Lavin, MD, Department of Surgery, College of Human Medicine, Giltner Hall, Michigan State University, East Lansing, Mich. 48824.

Figure I: A. Chest roentgenogram taken on 3/17/70 showing cardiomegaly and pulmonary venous congestion.



B. Pre-operative film showing extreme cardiomegaly with increase in size of all four chambers and marked pulmonary venous congestion.

C. Chest roentgenogram 3 months after surgery showing heart size reduced to be within normal limits and normal pulmonary vascularity.

For the following 18 months he had moderate dyspnea and fatigue, and a progressive increase in heart size on serial chest x-rays. *(Figure IA & B)*

The patient was readmitted for re-evaluation and surgery on 9/12/72. Physical examination disclosed a poorly developed asthenic child with breathlessness at rest. Weight was 62 pounds, height 55 inches. The pulse rate was 100 per minute and irregular, respiratory rate was 22 per minute. Jugular venous distention was present in the erect position. The precordium was hyperactive with a prominent left ventricular impulse. A pan-systolic grade IV/VI murmur was heard at the apex, which radiated to the axilla, and a soft systolic murmur of Grade III/VI intensity was present at the right sternal border which increased with inspiration. Bilateral crepitant rales were detected within the bases of both lungs. The electrocardiogram showed atrial fibrillation with biventricular hypertrophy. *(Figure II)* The chest x-ray showed extreme cardiomegally with increase in size of all four chambers and pulmonary venous congestion. Cardiac catheterization and angiography *(Table I)* disclosed massive mitral regurgitation, moderate tricuspid regurgitation and pulmonary hypertension. There was also trivial aortic regurgitation.

On 9/25/72 he underwent open heart surgery. Tricuspid valve exploration revealed moderate regurgitation due to dilatation of the annulus and annuloplasty rendered this valve competent. The mitral valve was found to be grossly regurgitant with thickened and retracted leaflets, the chordae tendinae were fused and matted. There was no possibility of rendering the valve competent by annuloplasty and after excision, a 33 mm. Hancock Xenograft was inserted. His immediate postoperative course was uncomplicated with the exception of a mild and self-limited post-cardiotomy syndrome. Three months following surgery the heart size was reduced to within normal limits and showed normal pulmonary vascularity *(Figure IC)* Clinically, the patient has shown marked improvement, is now completely asymptomatic on full activity, and has gained 12 pounds in weight.

V.L.

Table II

Cardiac Catheterization Case 2

	7/23/64		4/22/70		3/20/73	
	Pressures MM.HG.	O_2 Sat. %	Pressures MM.HG.	O_2 Sat. %	Pressures MM.HG.	O_2 Sat. %
SVC		51		71		
IVC		66				78
RA	10	67		68		70
RV	34	69	50-12	71	63/0-6	71
MPA			50-30	71	70-41	71
Wedge	13 Mean				a=35 v=41	98
LA	13	94				
LV					136/0-7	97
AsAO					108/70	94
LIPW					a=33 v=29	
LVEP					9-11	
RV dp/dt					1150-1380/sec.	
LV dp/dt					2430/sec.	
Pulm. Artery Resistance					8.3 units	
Valve Orifice					1. cm.	
CO					2.65 L/min	

Second Case

V.L. 155 01 99-6. This 8½-year-old white girl was the product of a full-term, normal pregnancy, weighing 7 pounds and 7 ounces at birth. At nine days of age, 7/23/64, she was admitted to Henry Ford Hospital in severe congestive heart failure. A right heart catheterization was performed. *(Table II)* Angiography showed a typical juxtaductal coarctation of the aorta. The infant improved on digitalis and diuretics, and surgery was deferred.

On 1/27/69 resection of the coarctation of the aorta was performed on an elective basis. Her postoperative course was uneventful and she was discharged 12 days later. Although reported to be symptom free, she was readmitted to Henry Ford Hospital on 4/22/70 for re-evaluation and assessment of apical systolic and diastolic murmurs. Right heart cardiac catheterization was again performed and revealed significant elevation of pulmonary arterial pressure and resistance. *(Table II)* Angiography showed an adequate repair of the coarctation. Left atrial enlargement was also present.

On 2/2/73 the child was admitted to another hospital in acute pulmonary edema *(Figure 3A)* which improved considerably after digitalization, diuretic therapy and fluid restriction. She was transferred to Henry Ford Hospital at which time the diagnosis was made of severe congenital mitral stenosis. Physical examination on admission revealed a small, chronically ill-looking white girl 37 inches tall and weighing 44½ pounds, placing her below the third percentile for age in height as well as weight. Her pulse was 90/minute, and regular; jugular venous distention was present;

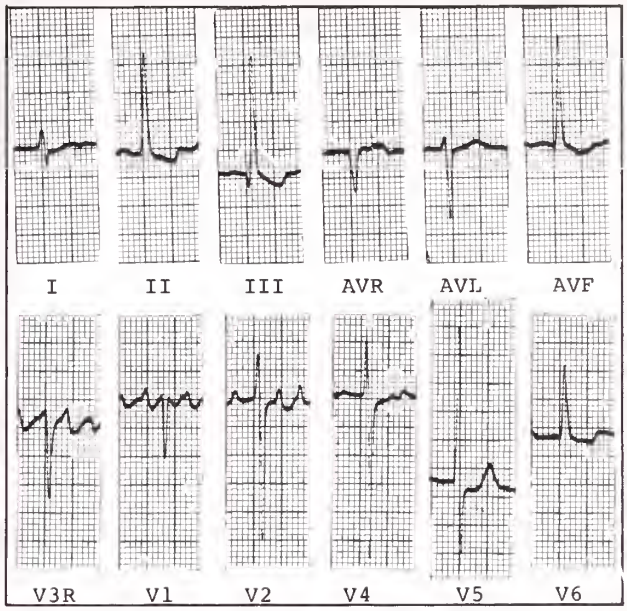


Figure II: Pre-operative electrocardiogram depicting atrial fibrillation and biventricular hypertrophy.

respirations were 22/minute, and her blood pressure was 118/40 mm. Hg. She had an active precordium. Both the first and second sounds were markedly accentuated. There was a grade III/VI mid-diastolic murmur with presystolic accentuation at the apex. No opening snap was detected or recorded on phonocardiography. A grade II/VI ejection systolic murmur was present at the apex and left sternal border. Bilateral crepitant rales were present at the bases. The abdomen was soft and without organomegaly. Femoral pulses were symmetrical and normal. Electrocardiogram

(Continued)

Figure III: A. Chest roentgenogram taken on 2/2/73 showing severe pulmonary congestion and edema.

B. Pre-operative film showing marked left atrial enlargement and pulmonary venous congestion.

C. Chest roentgenogram 3 months after surgery showing a slight decrease in heart size, left atrial prominence has disappeared and pulmonary vascularity is normal.

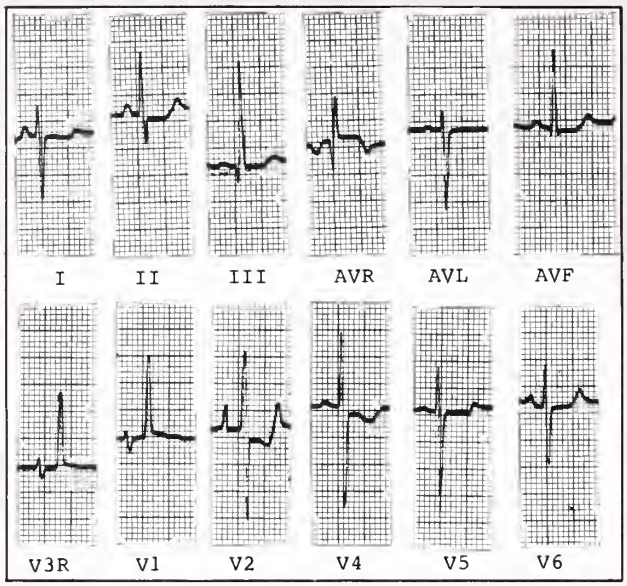


Figure IV: Pre-operative electrocardiogram depicting right axis deviation and right ventricular hypertrophy.

showed right axis deviation, varying atrial pacemaker and right ventricular hypertrophy. *(Figure IV)* Chest x-ray *(Figure III B)* showed moderate cardiomegaly and pulmonary venous congestion. Cardiac catheterization was performed on 3/20/73 and disclosed moderately severe pulmonary hypertension *(Table II)*

Angiography showed a large left atrial cavity, the mitral valve was noted to be markedly thickened with poor motion. A moderate degree of mitral regurgitation was noted. The ascending aorta and coronary arteries appeared normal. Mild narrowing was noted at the site of the resection of the coarctation of the aorta. A diagnosis of moderately severe mitral stenosis with regurgitation and subaortic stenosis was made.

On 3/23/73 the patient underwent open heart surgery. On opening the left atrium a supravalvular diaphragm with a 6 mm. central opening was found. *(Figure V)* There was a small 2-3 mm. infundibulum between this diaphragm and the actual mitral leaflets. The leaflets appeared thickened and retracted, allowing for the degree of mitral regurgitation noted at angiography. Two groups of papillary muscles were present. Due to the complexity of this malformed valve, no reconstructive procedure was deemed possible. The valve was removed along with a portion of the hypertrophic muscle in the subaortic area and a strip of thickened fibroelastotic endocardium. *(Figure VI)* A 25 mm. Hancock Xenograft valve was then inserted with multiple interrupted sutures. Postoperative pressures revealed a residual 40 mm. gradient across the left ventricular outflow tract while the patient was on Isoproterenol. This gradient was accepted in view of a satisfactory cardiac output. In the early postoperative course, she was troubled by supraventricular arrhythmias which responded to digitalis. She improved during the two or three ensuing days and had an uneventful postoperative recovery.

She was seen on 5/17/73 and was completely asymptomatic. She had gained six pounds of weight in two months. Pulse rate was 90/minute, respiration 18 and blood pressure 100/60. The precordium was quiet, the first and second heart sounds were normal. There was a grade II/VI ejection systolic murmur at the left sternal border. The lungs were clear. Chest x-ray showed slight decrease in heart size, left atrial prominence had disappeared and pulmonary vascularity was normal *(Figure III C)*

Comment

Mitral valvular defects in children are not uncommon and their clinical significance varies according to the degree of valve malfunction. They are classified into several groups, depending upon etiology: rheumatic fever, congenital malformed valves,[21-25] hereditary connective tissue defects,[26-28] and those who develop valvular disease as a result of endocarditis[29] or chest trauma.[30,31] Patients with congenital valvular malformations have an early onset and rapid progression of symptoms. Due to the usual severity of valve malfunction, surgical treatment is advised within the first few years of life.[32-35] A similar clinical course may be followed by those patients having valvular heart disease due to hereditary connective tissue disorders.[26,36,37]

Acquired valvular heart disease in childhood is mainly due to rheumatic fever, and mitral regurgitation is the most common lesion observed in this age group.[38,39] Here again, the degree of impairment of cardiac function is related directly to the severity of valve malfunction. Those patients with mild valvular dysfunction tolerate the hemodynamic burden for years without progression of symptoms; severe valvular damage is, in general, the end result of exacerbations or recurrences of this disease over a relatively brief period of time with extreme impairment of left ventricular function. When surgery becomes imperative, the choice of the most satisfactory operation has been problematic.

Closed heart procedures for the congenitally stenotic valve have proven of limited benefit, basically due to the complexity and variety of valve malformations; consequently, open heart surgery is the preferable approach. Plastic reconstruction of congenitally regurgitant valves has met with only limited success.[1,40] Prosthetic valve replacement in this age group has been undertaken with serious reservations in the past and the difficulties encountered here have been repeatedly emphasized.[41-48]

The main deterrent to the use of mechanical

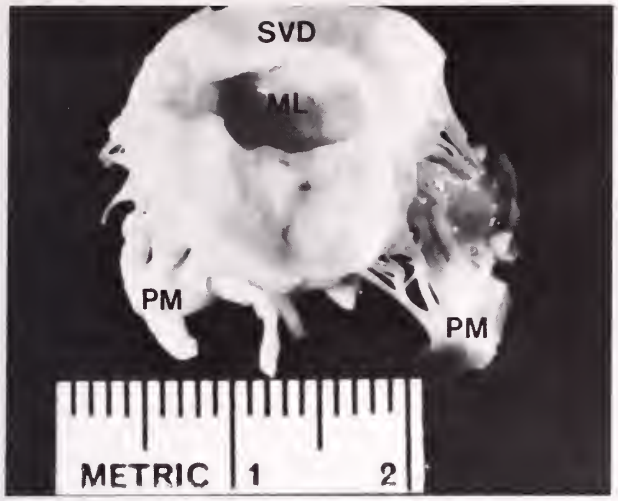
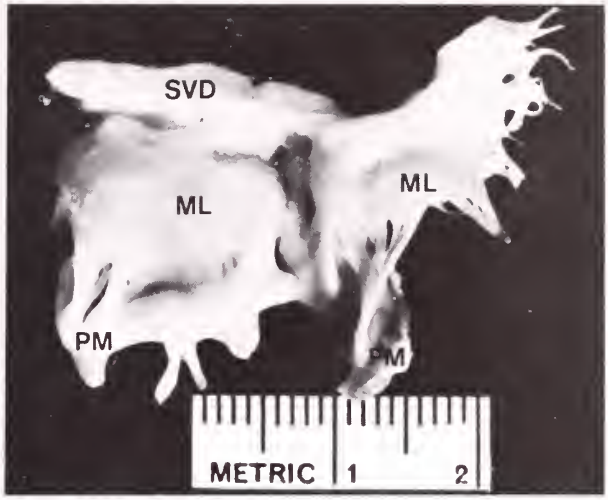


Figura V: A. Surgical specimen. S.V.D. = supravalvular diaphregm; M.L. = anterior mitral laaflet; P.M. = papillary musclas.



B. Spaciman opanad to show tha infundibular chambar batwaan S.V.D. and M.L. Again tha two groups of papillary musclas ara shown.

prostheses in children has been the concern that secondary replacement would be required as the children grow. This is a critical problem when dealing with stenotic valvular lesions where the valve annulus is usually very small, limiting the size of the prosthetic valve.

In recent years, important improvements have been made in the field of valve substitutes. With the advent of low profile,[11,12] and the cloth covered prostheses,[9,10] the incidence of thromboembolism or outflow tract obstruction will undoubtedly decrease. In the field of biological tissue valves, better methods of valve preservation have made it possible to store fresh and viable homograft valves up to eight weeks in a nutrient medium.[16] These valves have excellent long term function.[14,15] Also because of improved valve preservation, the porcine xenograft valves maintain a more stable protein linkage and, therefore, better durability.[13] These two biologic valves offer the largest effective valve area of all available valve substitutes, providing excellent hemodynamics and virtually no thromboembolism. With these inherent advantages they are most likely the best valve substitutes for children.

Our first case with grossly dilated mitral annulus accepted an adult size valve which will be more than adequate for normal hemodynamics during and after adolescence. The calculated effective orifice of a 33 mm. xenograft is 550 sq. mm.[50] The second case had a severely malformed valve in addition to a subaortic muscular obstruction and coarctation of the aorta, belonging to the developmental complex of obstructive anomalies of the left side of the heart as described by Shone, et al.,[49] with the exception that in our case the mitral valve had two groups of papillary muscles. It was similar to Case #5 described by Davachi, Moller and Edwards[51] with supravalvular rings. The value of biological valves was evident in this case as the severely malformed and stenotic annulus, as well as small left ventricular cavity, would not have accepted an adequate size prosthetic valve. A 25 mm. xenograft valve was inserted, having a calculated valve area of 300 sq. mm., which will allow adequate hemodynamics even at full growth of this child, making the necessity for second replacement unlikely.

The clinical results in these patients have been excellent as demonstrated by reduction in heart size, resumption of body growth and normal physical activities.

At present, we concur with the impression that complete correction of the hemodynamic valvular defect transcends the importance of possible future complications arising from the valve substitutes.

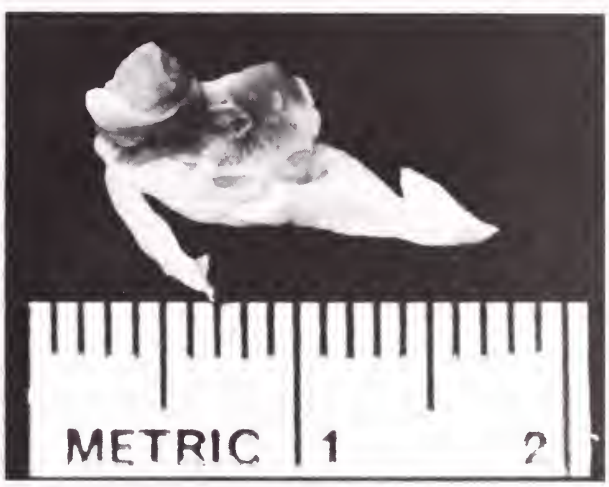


Figura VI: Excisad hypertrophic muscla in the subaortic araa with a strip of thickanad fibroelastotic andocardium.

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(Continued)

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external source, thereby avoiding direct responsibility. This externalization makes the task of understanding something as complicated and incomprehensible as the brain much easier. Tangible entities such as rocks can be treated concretely. Guilt, anxiety, conflict and moral responsibility are much more difficult problems.

Some scholars believe that the stone extraction theme was purely satirical, a pleasant diversion from religious art.[2] Others give a strictly religious interpretation, stating that the true meaning is the futility of all worldly healing.[13,14] By this interpretation the charlatan surgeon is, like Satan, a tempter whose schemes are extremely dangerous. Continuing this logic, madness is sin and attempting to cure madness through surgery is sheer folly. Both the religious and the satirical interpretations have historical support, for medicine itself was attacked by some pious individuals and satirized during this period. An influential cleric, Geiler of Kaiserberg, said in a well known sermon "Thou fool, why art thou proud of thy physic *(medicine)* by which thou are wounded, the virtues are a physic of the soul."[14] Sebastian Brant, in *The Ship of Fools (1494)* mocked the ignorant physician. In the popular satire *Praise of Folly (1509)*, Erasmus said that medicine was the art most akin to folly. An interesting coincidence is that Erasmus *(c. 1466—1536)* and Bosch *(c. 1450—c. 1516)* were contemporaries and both studied in the town of s'Hertogenbosch. Whatever the interpretation of the stones of madness, they are a unique phase of the history of medicine in art.

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Vice President Gerald Ford (left) chats with Brock E. Brush, MD, (second from left), MSMS president-elect, and Doctor and Mrs. Robert C. Prophater of Bay City at MDPAC's Washington reception for lawmakers.

Mrs. S. A. Yannitelli, wife of Battle Creek physician, shares a chuckle with Rep. Garry Brown (3rd Dist.) of Schoolcraft.

MDPAC Fetes Vice President at Reception

As might be expected, Vice President Gerald Ford's presence provided added excitement when the Michigan Doctors Political Action Committee gave a reception for Michigan lawmakers March 14 in Washington.

During MDPAC's 3rd annual Washington visit, 33 members of Michigan physician families conferred with members of the AMA legislative staff, toured the District of Columbia and entertained Sen. Robert Griffin, Vice President Ford and a dozen Michigan members of the House of Representatives.

Rep. Richard VanderVeen (5th Dist.), Grand Rapids, and Mrs. VanderVeen (right) talk with Mrs. Robert J. Westerhoff, whose husband is a Grand Rapids physician.

Sen. Robert P. Griffin of Traverse City (second from left) explains his views to Doctor and Mrs. Charles Oppy, of Roscommon, and their daughter, Elizabeth.

Donald W. Riegle, Jr. (7th Dist.), from Flint, and Mrs. James J. Gibbons, also from Flint, who attended the reception with her physician husband, enjoy a light moment.

MSMS House of Delegates Will Meet May 5-7 at Boyne Mountain Lodge

The MSMS House of Delegates 1974 Annual Session May 5-7 at Boyne Mountain Lodge, Boyne Falls, will mark a change in the society's annual meeting from fall to spring.

No elections will be held at the 1974 Annual Session, with officers installed last fall to continue in office until the next Annual Session in the spring of 1975.

The MSMS Council will meet May 5 at Boyne Falls, just before the opening of the House of Delegates session.

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Rural Health

Michigan Hosts AMA Conference

Innovations which are helping to solve problems in rural health care delivery will be in the spotlight April 25 and 26 when the AMA hosts a major national meeting in Detroit.

The event, the 27th National Conference on Rural Health, sponsored by the AMA's Council on Rural Health, is expected to attract 600 physicians, health care administrators, civic leaders, educators and students from throughout the country.

Michigan Role

Robert E. Rice, MD, of Greenville, a member of the Council on Rural Health, will have a major role at the conference. He will be joined in the opening day's program by Brooker L. Masters, MD, MSMS president, who will welcome the visitors to Michigan. Malcolm C. Todd, MD, AMA president-elect, is to give the keynote address on "A National Strategy for Rural Health."

Major work of the conference is expected to come in workshop sessions which will be in progress both days. Among consultants providing leadership for these sessions will be John G. Wiegenstein, MD, of Lansing, a member of the HEW advisory committee on emergency medical service, and John A. Doherty, executive vice president of the Michigan Health Council.

Student Program

MHC President John C. McCabe, who also heads Michigan Blue Shield, is to conduct the program at a luncheon to be given for students on the opening day by MHC and the Ford Motor Company.

Russell G. Mawby, PhD, president of the Kellogg Foundation, Battle Creek, is to speak at the opening day's general luncheon.

Prior to the conference, on April 24, the AMA Rural Health Council will conduct a seminar for extension specialists in health education and related fields, also in the Detroit Hilton.

Welcome

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

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(Continued on Page 224)

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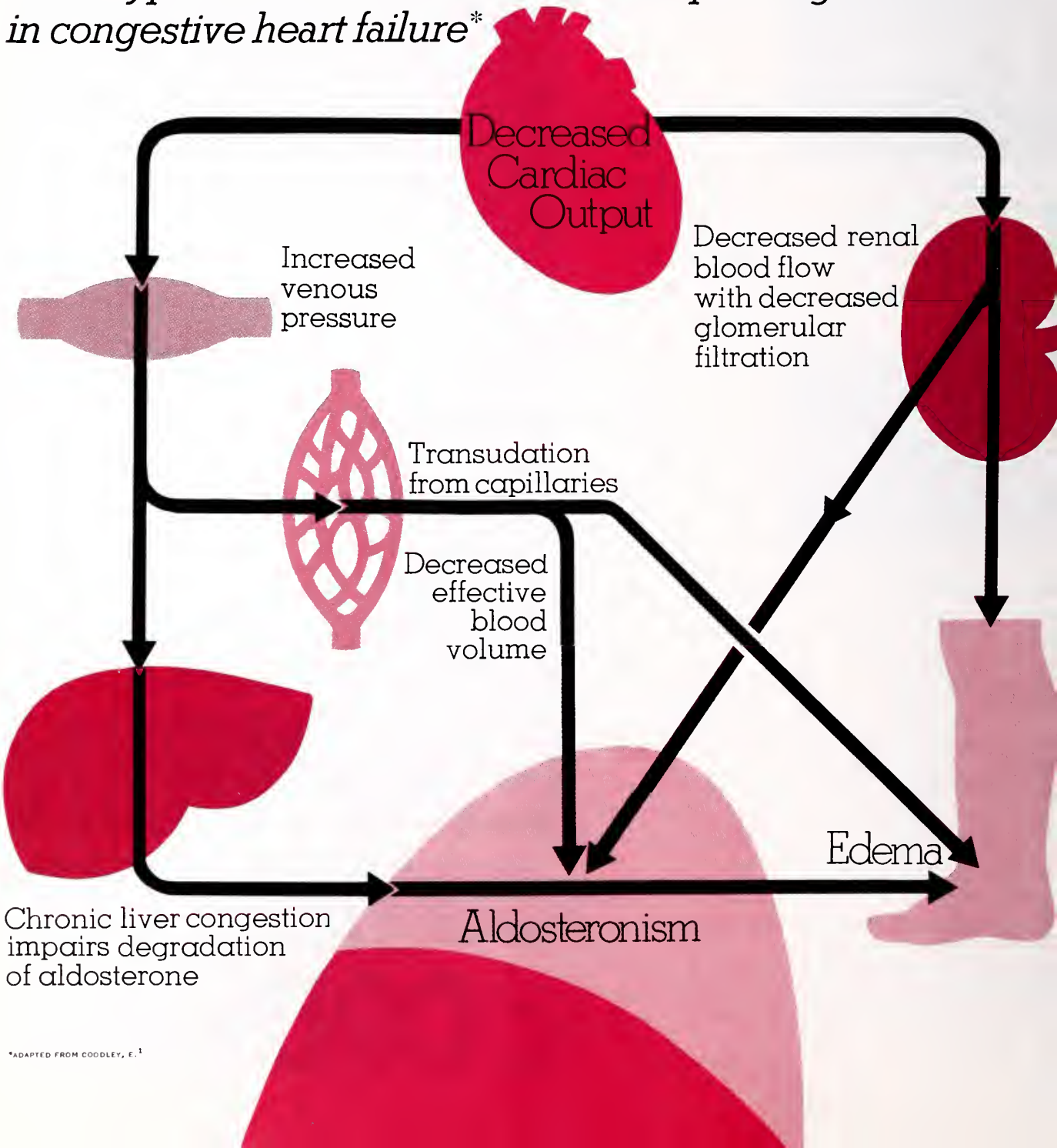
In congestive heart failure...

secondary aldosteronism

*How hyperaldosteronism leads to and prolongs edema in congestive heart failure**



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Three ways to use Aldactone in congestive heart failure

1. As the only diuretic

- Often sufficient alone.
- Produces gradual, sustained diuresis by blocking aldosterone action in the distal renal tubule.
- Avoids potassium loss.

2. As the basic daily diuretic with an "add-on" alternate-day-diuretic ("A.D.D." schedule)

- Can be administered daily as basic therapy with the additional agent (furosemide or ethacrynic acid) given every second or third day.
- Aldactone plus "A.D.D." schedule minimizes potassium deficiency and potentiates effect of "add-on" diuretic.[2]
- Avoids acute volume depletion and aldosterone rebound.[2]

3. As a daily diuretic in combination with a daily dose of a thiazide

- Permits daily additive diuretic effect while maintaining potassium balance.

Indications—Essential hypertension; edema or ascites of congestive heart failure, cirrhosis of the liver and the nephrotic syndrome; idiopathic edema. Same patients with malignant effusions may benefit from Aldactone (spironolactone), particularly when given with a thiazide diuretic.

Contraindications—Acute renal insufficiency, rapidly progressing impairment of renal function, anuria and hyperkalemia.

Warnings—Potassium supplementation may cause hyperkalemia and is not indicated unless a glucocorticoid is also given. Discontinue potassium supplementation if hyperkalemia develops. **Usage of any drug in women of childbearing age requires that the potential benefits of the drug be weighed against its possible hazards to the mother and fetus.**

Precautions—Patients should be checked carefully since electrolyte imbalance may occur. Although usually insignificant, hyperkalemia may be serious when renal impairment exists; deaths have occurred. Hyponatremia, manifested by dryness of the mouth, thirst, lethargy and drowsiness, together with a low serum sodium may be caused or aggravated, especially when Aldactone is combined with other diuretics. Elevation of BUN may occur, especially when pretreatment hyperazotemia exists. Mild acidosis may occur. Reduce the dosage of other antihypertensive drugs, particularly the ganglionic blocking agents, by at least 50 percent when adding Aldactone since it may potentiate their action.

Adverse Reactions—Drowsiness, lethargy, headache, diarrhea and other gastrointestinal symptoms, maculopapular or erythematous cutaneous eruptions, urticaria, mental confusion, drug fever, ataxia, gynecomastia, inability to achieve or maintain erection, mild androgenic effects, including hirsutism, irregular menses and deepening voice. Adverse reactions are infrequent and usually reversible.

Dosage and Administration—For **essential hypertension** in **adults** the daily dosage is 50 to 100 mg. in divided doses. Aldactone may be combined with a thiazide diuretic if necessary. Continue treatment for two weeks or longer since an adequate response may not occur sooner. Adjust subsequent dosage according to response of patient.

For edema, ascites or **effusions** in **adults** initial daily dosage is 100 mg. in divided doses. Continue medication for at least five days to determine diuretic response; add a thiazide or organic mercurial if adequate diuretic response has not occurred. Aldactone dosage should not be changed when other therapy is added. A daily dosage of Aldactone considerably greater than 75 mg. may be given if necessary.

A glucocorticoid, such as 15 to 20 mg. of prednisone daily, may be desirable for patients with extremely resistant edema which does not respond adequately to Aldactone and a conventional diuretic. Observe the usual precautions applicable to glucocorticoid therapy; supplemental potassium will usually be necessary. Such patients frequently have an associated hyponatremia—restriction of fluid intake to 1 liter per day or administration of mannitol or urea may be necessary (these measures are contraindicated in patients with uremia or severely impaired renal function). Mannitol is contraindicated in patients with congestive heart failure, and urea is contraindicated with a history or signs of hepatic coma unless the patient is receiving antibiotics orally to "sterilize" the gastrointestinal tract.

Glucocorticoids should probably be given first to patients with nephrosis since Aldactone, although useful for diuresis, will not directly affect the basic pathalagic process.

For **children** the daily dosage should provide 1.5 mg. of Aldactone per pound of body weight.

References: 1. Coadley, E.: Consultant 12:106-107, 109, 111, 113, 115 (July) 1972. **2.** Thorn, G. W., and Louler, D. P. Am. J. Med. 53:673-684 (Nov.) 1972.

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Indications: Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. Also, mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, descreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

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The Weight of Professional Opinion

It's time for action to defend the laws and regulations that protect your patients against drug substitution.

These professional and trade organizations are united in supporting antisubstitution statutes and regulations:

The American Academy of Dermatology

The Board of Directors of the American Academy of Family Physicians

The Executive Board of the American Academy of Neurology

The Committee on Drugs of the American Academy of Pediatrics

The American College of Allergists

The Executive Committee of the American College of Obstetricians and Gynecologists

The Board of Regents of the American College of Physicians

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The Board of Trustees of the American Medical Association

The American Psychiatric Association

The Executive Committee of the National Association of Retail Druggists

The Board of Directors of the Pharmaceutical Manufacturers Association

The National Wholesale Druggists' Association

Joint Statement on Antisubstitution Laws and Regulations

The purpose of this statement is to affirm the support of the participating organizations for the laws, regulations and professional traditions which prohibit the unauthorized substitution of drug products.

Traditionally, physicians, dentists and pharmacists have worked cooperatively to serve the best interests of patients. Productive cooperation has been achieved through mutual respect as well as a common concern for the ideals of public service. This mutual respect has been reflected, in part, by joint support over the years for the adoption and enforcement of laws and regulations specifically prohibiting unauthorized substitution and encouraging joint discussion and selection of the source of supply of drug products. The basic principles of medical, dental and pharmacy practice are thus utilized and preserved in the interest of patient welfare.

The antisubstitution laws have not obstructed enhancement of the professional status of pharmacy any more than they have in and of themselves guaranteed absolute protection from unsafe drugs, or freed physicians, dentists and pharmacists from their responsibilities to patients. As a practical matter, however, such laws and regulations encourage interprofessional communications regarding drug product selection and assure each profession the opportunity to exercise fully its expertise in drug usage, to the advantage of patients.

Physicians and dentists should be urged to increase the frequency and regularity of their contacts with pharmacists in selection of quality drug products, recognizing that economies to patients can be improved through such communication, taking into account the patients' needs. The pharmacist's knowledge of the chemical characteristics of drugs, their mode of action, toxic properties and other characteristics that assist in making drug selection decisions should be utilized to the fullest extent practicable by physicians and dentists in serving their patients.

Since drug product selection entails knowledge derived from clinical experience, the physician's and dentist's roles in product selection remain primary and do not permit delegation of decisions requiring medical and dental judgments. A broader role in therapy will evolve for pharmacists as improved understanding and cooperation among the professions continue to grow.

There has been no evidence that there are convincing reasons to modify or repeal existing laws and regulations prohibiting the unauthorized substitution of another drug product for the one specified by a prescriber. It is our belief that such laws and regulations merit the joint support of the medical, dental and pharmaceutical professions and the pharmaceutical industry.

Add your opinion to the weight of other professionals and send it to your state assemblyman or legislator.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D. C. 20005

P·M·A

Placidyl®
(ETHCHLORVYNOL)
Brief Summary

Indications—Placidyl (ethchlorvynol) is indicated as short-term hypnotic therapy in the management of insomnia.

Contraindications—Drug hypersensitivity and porphyria.

Warnings—Not recommended during the first and second trimester of pregnancy. Caution patients of possible combined exaggerated effects with alcohol, barbiturates, tranquilizers or other CNS depressants. Exaggerated effects might result in blurring of vision, paralysis of accommodation and profound hypnosis. Caution patients concerning driving a motor vehicle, operating machinery, or other hazardous operations requiring alertness after taking the drug. Administer with caution to patients with suicidal tendencies and do not prescribe large quantities of the drug. Adjustment of the dosage of oral anticoagulants might be necessary when beginning ethchlorvynol therapy, during therapy, or after stopping therapy. This drug is not recommended for use in children. PLACIDYL HAS THE POTENTIAL FOR THE DEVELOPMENT OF PSYCHOLOGICAL AND PHYSICAL DEPENDENCE. INSTANCES OF SEVERE WITHDRAWAL SYMPTOMS, INCLUDING CONVULSIONS AND DELIRIUM CLINICALLY SIMILAR TO THOSE SEEN WITH BARBITURATES, HAVE BEEN REPORTED IN PATIENTS TAKING REGULAR DOSES AS LOW AS 1000 MG. PER DAY OVER A PERIOD OF TIME WHEN THE DRUG WAS SUDDENLY DISCONTINUED. PROLONGED ADMINISTRATION OF THE DRUG IS NOT RECOMMENDED. Addiction-prone patients or those who are likely to increase dosages of the drug on their own initiative should be observed for evidence of signs or symptoms which may indicate possible early withdrawal or abstinence symptoms. Signs and symptoms associated with withdrawal and abstinence include unusual anxiety, tremor, ataxia, slurring of speech, memory loss, perceptual distortions, irritability, agitation and delirium. Other less well defined signs and symptoms, not necessarily due to withdrawal and abstinence, may include anorexia, nausea or vomiting, weakness, dizziness, sweating, muscle twitching and weight loss. Abrupt discontinuance of Placidyl following prolonged overdosage may result in convulsions and delirium.

Precautions—Toxic amblyopia has been reported with long-term continuous use of ethchlorvynol. Permanent visual defects have been observed, although amblyopia has improved after discontinuation of the drug. Drug dosage should be limited for elderly and debilitated patients to the smallest effective amount. If pain is present, this drug should only be given if insomnia persists after pain is controlled with analgesics. Caution is advised in prescribing the drug for patients who are being treated with either MAO inhibitors or antidepressants. Transient delirium has been reported with the combination of Placidyl and amitryptyline. Drug dosage should be reduced if prescribed for patients receiving MAO inhibitors or antidepressants. Caution should be exercised in patients with impaired hepatic or renal function. Patients who respond unpredictably to barbiturates or alcohol, or who exhibit excitement and release of inhibition in association with such agents, may also react in this way to Placidyl. Rarely, patients may exhibit symptoms suggestive of an unusual susceptibility to the drug; such as prolonged hypnosis, profound muscular weakness, excitement, hysteria, or syncope without marked hypotension. Transient giddiness or ataxia may occur.

Adverse Reactions—Hypotension, nausea or vomiting, gastric upset, aftertaste, blurring of vision, dizziness, facial numbness, and allergic reaction typified by urticaria have been reported following Placidyl administration. Mild "hangover" and symptoms of mild excitation have occurred in some patients. There have been rare reports of cholestatic jaundice occurring in patients taking ethchlorvynol. A few cases of thrombocytopenia have been reported in patients receiving ethchlorvynol. 302430R

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Physician Urges Military to Share Drug Test Data

Editor, *Michigan Medicine*

Pharmacist Timberlake in his paper on quality drug products in your January, 1974, issue (Production of Quality Drug Products Demands Never Ending Attention: Claude V. Timberlake, RPH, *Michigan Medicine* **73:** 2, 38) describes the careful testing by the Defense Department of generic drug samples obtained from the lowest bidder, including inspection of their facilities and personnel, whereby 40 to 50 per cent are rejected.

He points out that of 951 drug recalls by FDA in 1970, only one of these had entered the military medical supply system, and he indicates that "the medicinal products found unsatisfactory for use by the military" are evidently sold to us civilians.

He has succeeded in arousing my indignation, though I reject his conclusion — to prescribe only the highest priced brand name!

The real answer is that the results of this costly surveillance by the Defense Department must not be kept a secret from the FDA and from us civilians who pay for it all, but must be made publicly known. There is no reason why we cannot have high quality generic drugs at the same low prices paid by the military.

It is indeed shocking that the "dedicated personnel of the military medical procurement agency" have such contempt for us civilians as to permit their rejects to be sold to us.

Sincerely,
Sam I. Lerman, MD
Detroit

North Carolina Physician Asks Views from Michigan

Dear Editor:

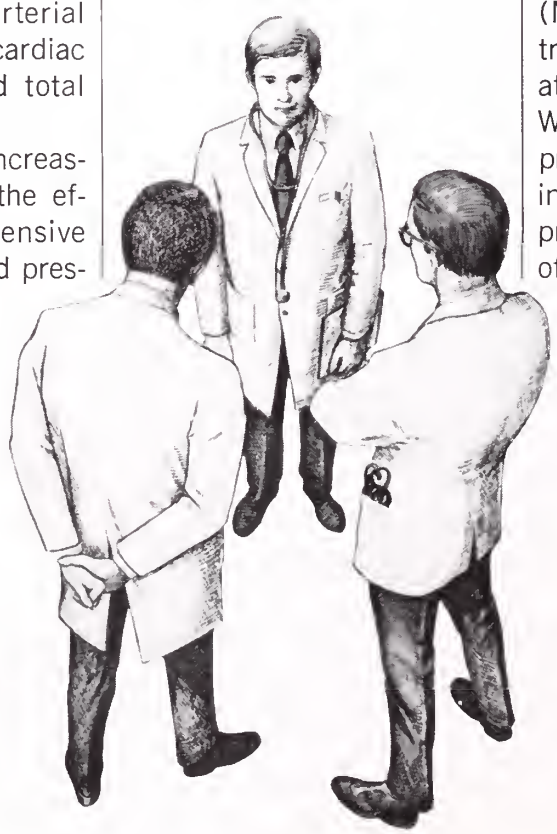
I am currently editing a book on the personal testimonies of Christian physicians and how they view the current medical-ethical issues of today, i.e., abortion, euthanasia, organ transplants, when is a person officially dead, sterilization, psycho-surgery, semen donors, ovum donors, host mothers, reversed aging, artificial organs, genetic counseling, etc. I would be interested in hearing from any Christian physician who would be interested in contributing to such a book or who would be able to suggest a Christian physican to write for this book. Please contact me at the following address:

Claude A. Frazier, MD
4-C Doctor's Park
Asheville, N.C. 28801.

The more physicians consider the hemodynamics of lowering blood pressure...

Most physicians now agree on the importance of reducing blood pressure in the hypertensive patient. But high blood pressure exists, of course, only as part of a complete clinical picture. The hemodynamic profile of well-established essential hypertension is characterized by elevated arterial blood pressure, normal cardiac output, and increased total peripheral resistance.

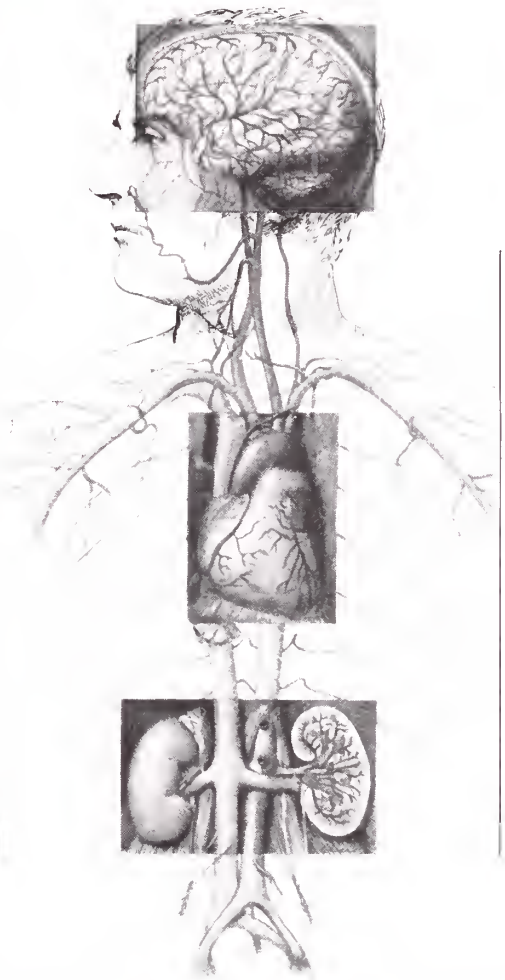
And so, physicians are increasingly concerned with the effects of an antihypertensive agent not only on blood pressure itself but also on the hemodynamic pattern—in short, with the total effect of the drug. *Does* it indeed help lower blood pressure effectively? *Is* peripheral resistance reduced? *Are* cardiac output and renal functions maintained? And, also, is there likely to be drug-induced postural hypotension serious enough to pose a threat to the patient's cerebrovascular status?



With this emphasis on overall drug performance has come a growing reliance on ALDOMET® (Methyldopa, MSD) in the treatment of sustained moderate hypertension.

With its unique hemodynamic profile, ALDOMET has drawn increasing attention and approval from physicians. First, of course, for its efficacy in

the more physicians rely on this unique antihypertensive



lowering blood pressure. But there are other considerations as well. Cardiac output is usually maintained with no cardiac acceleration; in some patients the heart rate is actually slowed. Peripheral resistance is apparently reduced. ALDOMET does not usually compromise existing renal function; it generally does not reduce renal blood flow, glomerular filtration rate, or filtration fraction. And ALDOMET usually does not cause symptomatic postural or exercise hypotension.

Some patients on continuous methyldopa therapy may develop a positive direct Coombs test. For more details, see the brief summary of prescribing information.

Contraindicated in active hepatic disease and known sensitivity to the drug. Not recommended in pheochromocytoma or pregnancy. It should be used with caution in patients with a history of liver disease or dysfunction. Discontinue the drug if fever, abnormal liver function, jaundice, or acquired hemolytic anemia occurs.

In most cases of sustained moderate hypertension

TABLETS, 250 mg

ALDOMET®
(METHYLDOPA | MSD)

smoothly lowers blood pressure

For a brief summary of prescribing information, please see following page.

In most cases of sustained moderate hypertension

TABLETS, 250 mg

ALDOMET® (METHYLDOPA MSD)

smoothly lowers blood pressure

Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis; known sensitivity. Not recommended in pheochromocytoma. Unsuitable in mild or labile hypertension responsive to mild sedation or thiazide therapy. Use cautiously in patients with history of previous liver disease or dysfunction.

Warnings: Acquired hemolytic anemia has occurred rarely in association with therapy with methyldopa. Should clinical symptoms indicate the possibility of anemia, hemoglobin and/or hematocrit determinations should be performed. If anemia is present, appropriate laboratory studies should be done to determine if hemolysis is present. Evidence of hemolytic anemia is an indication for discontinuation of the drug. Discontinuation of methyldopa alone or the initiation of adrenocortical steroids usually results in a prompt remission of the anemia. Rarely, however, fatalities have occurred.

Some patients on continued therapy with methyldopa develop a positive direct Coombs test; incidence reported has averaged between 10% and 20%. It rarely occurs in first six months of therapy, and if not seen within twelve months, is unlikely to develop with continued administration. Positive Coombs test is dose-related; lowest incidence occurs in patients on 1 g methyldopa or less per day. Reversal of the positive Coombs test occurs within weeks to months after discontinuation of methyldopa. Prior knowledge of a positive Coombs reaction aids in evaluation of cross match for transfusions. Patients with positive Coombs tests at time of cross match may exhibit incompatible minor cross match. When this occurs, an indirect Coombs test should be performed. If negative, transfusion with blood otherwise compatible in the major cross match may be carried out. If positive, advisability of transfusion with blood compatible in major cross match should be determined by hematologist or expert in transfusion problems.

Fever has occurred within first three weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first two to three months of therapy. Rare cases of fatal hepatic necrosis have been reported. Liver biopsy in several patients with liver dysfunction has shown microscopic focal necrosis compatible with drug hypersensitivity. Rarely, reversible reduction in leukocyte count with primary effect on granulocytes has been seen; reversible agranulocytosis has been reported. Methyldopa may interfere with measurement of creatinine by alkaline picrate method and of uric acid by phosphotungstate method. When used with other antihypertensive drugs, potentiation of antihypertensive action may occur.

Usage in Pregnancy and Childbearing Age—Not recommended in pregnancy. In women of childbearing age, weigh potential benefits against possible fetal hazards.

Precautions: Perform periodic hepatic function tests and white cell and differential blood counts during first six to twelve weeks of therapy or in unexplained fever. Discontinue if fever, abnormalities in liver function tests, or jaundice appears. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, spuriously high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. Discontinue drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Anesthetics requirements may be reduced; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension may occur after dialysis because methyldopa is removed by this procedure.

Dosage should be limited initially to 500 mg daily when following previous antihypertensive agents other than thiazides. Do not exceed recommended daily dose of 3.0 g. Patients with impaired renal function may respond to smaller doses than patients with normal kidney function. Syncope in older patients has been related to increased sensitivity in those with advanced arteriosclerotic vascular disease; this may be avoided by lower doses. Tolerance occasionally seen either early or late, but more likely between second and third month after initiation of therapy; increased dosage or combined therapy with a thiazide frequently restores effective control.

Adverse Reactions: Sedation, usually transient, may be seen during initial therapy or when dosage is increased. Headache, asthenia, or weakness may be noted as early, transient symptoms. Symptoms associated with effective lowering of blood pressure, including dizziness, lightheadedness, and symptoms of cerebrovascular insufficiency, are seen occasionally. Angina pectoris may be aggravated. Symptoms of orthostatic and exercise hypotension may occur; if symptoms occur, reduce dosage. Bradycardia, nasal stuffiness, mild dryness of mouth, and gastrointestinal symptoms including distension, constipation, flatus, and diarrhea occur occasionally; these can be relieved by reducing dosage. Nausea and vomiting have been reported in only a few patients. Sore tongue or "black tongue," pancreatitis, and inflammation of salivary glands may occur.

Weight gain and edema occur infrequently; if edema progresses or signs of pulmonary congestion appear, discontinue drug. Rarely, urine exposed to air may darken due to breakdown of methyldopa or its metabolites. Other rare reactions include breast enlargement, lactation, impotence, decreased libido, skin rash, mild arthralgia, myalgia, paresthesias, parkinsonism, psychic disturbances including nightmares, reversible mild psychoses or depression, reversible thrombocytopenia, drug-related fever and abnormal liver function studies with jaundice and hepatocellular damage (see **Warnings** and **Precautions**), rise in BUN, and a single case of bilateral Bell's palsy.

Supplied: Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

MSD MERCK SHARP & DOHME

ADDENDUM

Let's make blood pressure "required reading" for all physicians.

With recent estimates that about 23 million Americans have high blood pressure—and that half of them are not even aware of it—detection of the problem in asymptomatic persons has become an issue of national importance.

Family physicians are being urged to take blood pressure readings as a matter of office routine, regardless of the presenting complaint or the reason for the visit. And because many people do not see a family physician for relatively long periods of time, some experts are suggesting that ophthalmologists, gynecologists, dermatologists, orthopedists, psychiatrists, dentists, school nurses, family planning counselors, and other health-care personnel make blood pressure reading a routine part of every examination or consultation.

Of course, a diagnosis of hypertension cannot be made on the basis of a single reading, but routine blood pressure readings can uncover potential trouble in a certain proportion of patients. And when trouble is suggested, further evaluation can be pursued more effectively.

Blood pressure—"required reading" for all physicians.

Commentary

SHOTS Would Provide State Financing for Graduate Medical Education

By Donald H. Kuiper, MD, Lansing

In this essay, I hope to familiarize the society members with a proposed new program for graduate medical education in Michigan. I will quote from the proposal throughout this paper.

Dr. Kuiper

Summary

"This proposal suggests the creation of a Statewide House Officer Training System (SHOTS) in the state of Michigan to fund and coordinate house officer training in the various specialties and subspecialties of allopathic and osteopathic medicine. A non-profit corporation would be created which would receive funds from state government to improve all forms of house officer training from the first postgraduate year to entry into practice. (This includes the traditional phases of internship, residency and clinical fellowship training; it would not include fellowships designed primarily for research training.) A central governance structure would be created with representation from community hospitals, educational institutions, third party insurance carriers, house officers and various professional groups. SHOTS would set admission standards for trainees, approve training program curricula, allocate funds, periodically evaluate both trainees and training programs and certify trainees to the appropriate specialty and subspecialty boards. Most importantly, SHOTS would gather reliable data on the physician manpower needs of the state of Michigan and would use this data as a major determinant of the types and numbers of house officer training programs conducted. Participation in SHOTS would be on an institutional rather than individual specialty program basis and would be voluntary rather than compulsory."

Background

In the fall of 1972, State Sen. Garland Lane of Flint held a discussion with John Gronvall, MD, Dean of the University of Michigan Medical School. The senator expressed his desire for an education program which would increase the number of practicing physicians in Michigan by increasing the number of physicians receiving graduate medical education in the state. (Physicians tend to enter practice in the state where they had their graduate education.)

Doctor Gronvall then appointed a committee composed of Calvin Dykman, MD, of Grand Rapids; Joseph Rinaldo, MD, of Southfield; Robert Tupper, MD, then of the Michigan Association of Regional Medical Programs, and J. K. Stross, MD, Roland Hiss, MD, and Neal Vanselow, MD, all of the University of Michigan

(Continued)

Michigan Medicine's new Commentary page will offer physicians and others the opportunity to express opinions on issues in medicine. Contributions are invited and should be submitted to Commentary, *Michigan Medicine,* 120 W. Saginaw St., East Lansing, Mich. 48823.

The views expressed here are those of the author and do not represent positions of the Michigan State Medical Society or opinions of the editors of *Michigan Medicine.*

Doctor Kuiper is Director of Medical Education at St. Lawrence Hospital in Lansing. His comments on the SHOTS proposal originally appeared in Medicina, published by the Ingham County Medical Society.

Medical Center. This group worked out the proposal known as SHOTS. The initial draft was referred to the Michigan Medical School Council of Deans, who then established a larger planning committee with representation from the Michigan Association of Medical Education, MSMS, Michigan Association for Osteopathic Physicians and Surgeons, Michigan Hospital Association, Michigan Osteopathic Hospital Association, Michigan Regional Medical Programs, the Kellogg Foundation, Blue Cross, Blue Shield, Michigan Medical School Council of Deans and the Office of Health and Medical Affairs of the Governor's Office. This new committee organized into four task forces with the following areas of activity:

1. The relationship of SHOTS to state government
2. The osteopathic/allopathic medicine interface
3. The governing body
4. Finances

The second draft of this statewide proposal is now available for consideration by the various interested groups. The stated objectives of the system are:

"1. To train high quality physicians for medical care delivery in the state of Michigan in accordance with defined physician manpower needs of the state.

"2. To improve the quality of training available to house officers in Michigan hospitals and other health care institutions.

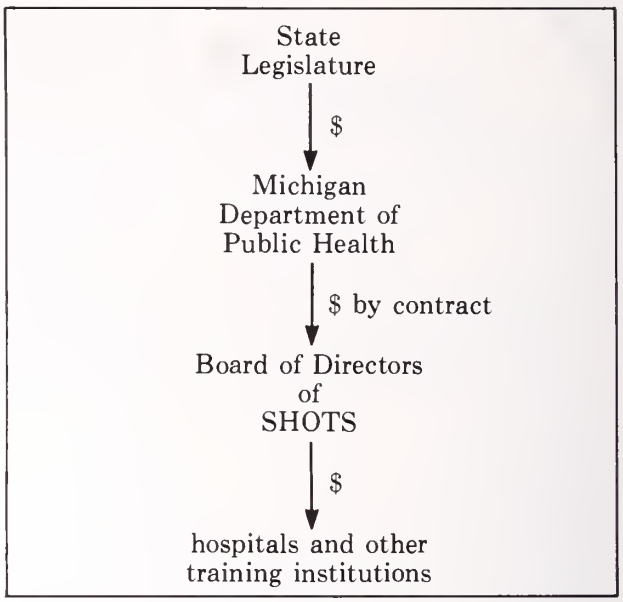
"3. To improve the quality of health care delivery in Michigan by attracting more and better house officers to the state.

"4. To establish an integrating mechanism for the system of house officer training in the state of Michigan.

"5. To supplement the present inadequate system of financing house officer training programs."

Governance

It is proposed that a private non-profit corporation be created to operate SHOTS. The non-profit corporation would request state funds to finance the house officer training system. These funds would be provided by the state legislature as an annual line item appropriation to the Michigan Department of Public Health, which would, in turn, contract with the non-profit corporation to operate SHOTS. The Board of Directors of SHOTS would thus be accountable to state government through the Michigan Department of Public Health.



The Board of Directors of SHOTS would also establish liaison with other agencies of state government which are concerned with the education and training of health professionals and with health care delivery. These include the Office of Health and Medical Affairs, the state office of Comprehensive Health Planning and the State Health Planning Advisory Council. Such liaison would be of particular importance to the development of a mechanism for determining Michigan's physician manpower needs.

A Board of Directors would be the policy-making body of SHOTS and would be responsible for the management of the statewide system. Its proposed composition would be:

A.	Deans of the four Michigan medical schools	4
B.	Community hospitals, appointed by the Michigan Association for Medical Education	4
C.	Insurance groups, Blue Cross, Blue Shield, Michigan Department of Social Services and the Health Insurance Council	4
D.	House officers to be nominated by hospitals and selected by the Board of Directors, at least one of whom shall be an osteopath	3
E.	Michigan State Medical Society	1
F.	Michigan Association of Osteopathic Physicians and Surgeons	1
G.	Michigan Hospital Association	1
H.	Michigan Osteopathic Hospitals Association	1
	Executive Director Ex-officio without vote	

(Continued on Page 236)

The post-T&A patient:
another type for Tylenol®
(acetaminophen)

When the post-T & A patient requires an analgesic, a new problem arises. Hemorrhagic tendencies following the use of aspirin after tonsillectomies have been reported![1,2] In a patient who "...has recently undergone a surgical procedure or has another underlying hemostatic defect, aspirin ingestion may cause significant bleeding....Aspirin is absolutely contraindicated in such situations. Acetaminophen...could replace aspirin in these instances."[3]

The post-T & A patient is only one of several 'types for TYLENOL'—that is, patients who should avoid aspirin. Considering all of them, wouldn't it provide added safety (as well as added convenience) to recommend TYLENOL (acetaminophen) routinely for simple analgesia?

References: 1. Reuter, S. H., and Montgomery, W. W.: Arch. Otolaryng. *80*:214-217 (Aug.) 1964. **2.** Osol, A., et al., ed.: The United States Dispensatory and Physicians' Pharmacology, ed. 26, Philadelphia, J. B. Lippincott Co., 1967, p. 171. **3.** Schwartz, A. D., and Pearson, H. A.: J. Pediat. *78*:558-560 (March) 1971.

Precautions and Adverse Reactions: If a rare sensitivity reaction occurs, the drug should be stopped. TYLENOL (acetaminophen) has rarely been found to produce any side effects.

Elixir, 120 mg./5cc. (alcohol 7%).
Drops, 60 mg./0.6cc. (alcohol 7%).
Chewable Tablets, 120 mg.

Safer than aspirin,
yet just as effective for relief
of pain and fever

Tylenol®
(acetaminophen)

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Minoo K. Rao, MD, 51203 Pheasant Run Dr., Saginaw 48603
Francisco J. Rodriguez, MD, 18342 Mack Ave., Grosse Pte. Farms 48236
Leonard J. Rosenthal, MD, 3556 O Margaret, Romulus 48174
Phairatch Sarnsethsiri, MD, 7377 Byron, Detroit 48202
Victor R. Scarano, MD, 3800 Woodward, Detroit 48201
George P. Schanz, MD, 3053 Shattuck Arms Blvd., Saginaw 48603
Jan Schneider, MD, University Medical Center, Ann Arbor 48104
Daniel Schnuda, MD, Wyandotte General Hospital, Wyandotte 48192
William H. Scott, MD, 2901 S. Westnedge, Kalamazoo 49001
Anil Kumar Sil, MD, 25210 Grand River, Detroit 48240
Paul R. Simmons, MD, 1100 Sixth St., Traverse City 49684
C. Soontharotoke, MD, 705 Cooper, Saginaw 48602
John L. Stephenson, MD, 412 S. Cedar, Allegan 48010
Allan D. Stilwell, MD, St. Joseph Mercy Hospital, Pontiac 48053
Genevieve D. Swanson, MD, 1810 Wealthy St., SE, Grand Rapids 49506
Glinda P. Tugade, MD, 3516 Fort St., Lincoln Park 48146
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Mercywood Hospital is a private neuropsychiatric hospital licensed by the Michigan Department of Mental Health. Mercywood specializes in intensive, multi-disciplinary treatment for emotional and mental disorders.

Accredited by the Joint Commission on Accreditation of Hospitals and the National League of Nursing. A full Blue Cross participating hospital.

Certified for: Medicare and M.A.A. programs

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Robert M. Zimmerman, M.D.

Maybe the patient's self-diagnosis is right. He could have hay fever. But that bright red nasal mucosa, along with the thick discharge and excoriation around the nares, strongly suggests that the main problem is a cold. Hay fever or another form of allergic rhinitis may or may not be an underlying factor.

If a complete history and examination rule out allergic rhinitis, the long-term outlook will be a lot more favorable than his own "diagnosis" would have indicated.

But right now, whether he's got allergic rhinitis or a cold, he's suffering from the same irritating symptoms of drip, congestion and stuffiness. Try DIMETAPP EXTENTABS®. They're formulated to relieve these symptoms without much chance of causing drowsiness or overstimulation. Your patients will appreciate the 24-hour relief they can get from just one tablet every 12 hours.

Cold or

Allergy?

Whether it's a cold or an allergy, Dimetapp Extentabs® effectively relieve stuffiness, drip and congestion.

INDICATIONS: Dimetapp Extentabs are indicated for symptomatic relief of allergic manifestations of upper respiratory illnesses such as the common cold, seasonal allergies, sinusitis, rhinitis, conjunctivitis and otitis. In these cases it quickly reduces inflammatory edema, nasal congestion and excessive upper respiratory secretions, thereby affording relief from nasal stuffiness and postnasal drip.

CONTRAINDICATIONS: Hypersensitivity to antihistamines of the same chemical class. Dimetapp Extentabs are contraindicated during pregnancy and in children under 12 years of age. Because of its drying and thickening effect on the lower respiratory secretions, Dimetapp is not recommended in the treatment of bronchial asthma. Also, Dimetapp Extentabs are contraindicated in concurrent MAO inhibitor therapy.

WARNINGS: *Use in children:* In infants and children particularly [illegible] in overdosage may produce convulsions and death.

PRECAUTIONS: Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. Until the patient's response has been determined, he should be cautioned against engaging in operations requiring alertness such as driving an automobile, operating machinery, etc. Patients receiving antihistamines should be warned against possible additive effects with CNS depressants.

Dimetapp Extentabs®

Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.

ADVERSE REACTIONS: [illegible] hypersensitivity [illegible] dizziness, [illegible] HOW SUPPLIED: [illegible] bottles of 100 and 500.

A·H·ROBINS

A. H. Robins Company, Richmond, Va. 23220

when pain goes on... and on... and on–

For the patient with a terminal illness, PAIN past, present, and future can dominate his thoughts until it becomes almost an obsession. The more he is aware of the pain he is now experiencing, the more difficult it is to erase his memory of yesterday's pain, and to allay his fearful anticipation of tomorrow's pain.

Surely the last thing this patient needs is an analgesic containing caffeine to stimulate the senses and heighten pain awareness. A far more logical choice is Phenaphen with Codeine. The sensible formula provides ¼ grain of phenobarbital to take the nervous "edge" off, so the rest of the formula can help control the pain more effectively. Don't you agree, Doctor, that psychic distress is an important factor in most of your terminal and long-term convalescent patients?

the analgesic formula that calms instead of caffeinates

Phenaphen® with Codeine

Phenaphen with Codeine No. 2, 3, or 4 contains: Phenobarbital (¼ gr.), 16.2 mg. (warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Codeine phosphate, ¼ gr. (No. 2), ½ gr. (No. 3) or 1 gr. (No. 4) (warning: may be habit forming).

Indications: Provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products, excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.

(III) Phenaphen with Codeine is now classified in Schedule III, Controlled Substances Act of 1970. Available on written or oral prescription and may be refilled 5 times within 6 months, unless restricted by state law.

A. H. Robins Company, Richmond, Va. A·H·ROBINS

Briefly Noted

Gerald J. Aben, MD, of Southfield,

has been installed as president of the medical staff of Providence Hospital, Southfield. Doctor Aben, a specialist in internal medicine, has been a member of the Providence staff since 1953. He is a graduate of the Wayne State University School of Medicine.

Robert W. Bailey, MD, of Ann Arbor,

will be a featured guest speaker at the 18th annual postgraduate course on fractures and other trauma to be held May 8-11 in Chicago by the Chicago Committee on Trauma of the American College of Surgeons. Doctor Bailey is professor of surgery at the University of Michigan Medical School.

William H. Blodgett, MD, of Detroit,

has been elected vice president of the American Orthopaedic Foot Society. Doctor Blodgett is chief of the orthopaedic section of Grace Hospitals and clinical associate professor of orthopaedics at Wayne State University School of Medicine.

Earl W. Campbell, MD, of East Lansing,

is the co-author, with Clinton L. Rogers, MD, of Cumberland, Md., of an article on "Submucosal Gallbladder Emphysema" published in the Feb. 18 issue of *JAMA*. Doctor Campbell is a member of the Michigan State University faculty.

Robert B. Carbeck, MD, of Ann Arbor,

has been elected to a two-year term as secretary-treasurer of the Association for Hospital Medical Education. Doctor Carbeck, head of the Department of Internal Medicine at St. Joseph Mercy Hospital, Ann Arbor, also is president-elect of the Michigan Association for Hospital Medical Education.

Reed O. Dingman, MD, of Ann Arbor,

has been awarded an honorary doctor of science degree by the University of Miami (Fla.) School of Medicine. He was cited for innovations and leadership in plastic surgery. Doctor Dingman is head of the University of Michigan plastic surgery section.

Lee E. Feldkamp, MD, of Plymouth,

has announced his candidacy for the board of directors of the American Academy of Family Physicians. Doctor Feldkamp, who served as president of the Michigan Academy of Family Physicians in 1968-69, is a charter fellow of the AAFP. The AAFP's annual meeting will be held Oct. 12-17 in Los Angeles.

Jacques S. Gottlieb, MD, of Detroit,

has retired as director of the Lafayette Clinic in Detroit after almost 20 years in the position. Doctor Gottlieb also has stepped down from his post as chairman of the Wayne State University department of psychiatry. MSMS last fall presented Doctor Gottlieb with a certificate of commendation for his achievements as a psychiatrist and educator. On March 8 he received a Distinguished Service Award from the WSU Board of Governors.

Beverly C. Payne, MD, of Ann Arbor,

is co-author, with Thomas F. Lyons, PhD, of Cleveland, of an article on "The Quality of Physicians' Health-care Performance: A Comparison Against Optimal Criteria for Treatment of the Elderly and Younger Adults in Community Hospitals" appearing in the Feb. 25 issue of *JAMA*.

James E. Waun, MD, of Ludington,

has been elected president of the Michigan Society of Anesthesiologists. Also elected were George J. Chatas, MD, of Ann Arbor, president-elect, and Bernard J. Sivak, MD, of Detroit, secretary-treasurer. Doctors Waun, Chatas and Sivak also serve as officers of the MSMS anesthesiology section.

Myron E. Wegman, MD, of Ann Arbor,

will leave his position as dean of the University of Michigan School of Public Health on July 1 to return to U-M research and teaching of international problems in public health. U-M President Robben Fleming announced the appointment of Richard D. Remington, PhD, now associate dean of the University of Texas School of Public Health, to succeed Doctor Wegman, noting: "He will succeed one of the moving spirits of the American public health schools. Myron Wegman is a distinguished physician who has helped place his school in the forefront of American public health schools."

Chris J. D. Zarafonetis, MD, of Ann Arbor,

an army medical corps colonel who has completed 36 years of active and reserve duty, has been awarded the Legion of Merit for outstanding service. Doctor Zarafonetis is professor of internal medicine at the University of Michigan Medical School.

Education

Who's Who at Michigan

University of Michigan Medical School

Administration

John A. Gronvall, MD, *Dean and Director of the Medical Center*
Robert A. Green, MD, *Associate Dean for Student Affairs*
George R. DeMuth, MD, *Associate Dean*
Thomas J. Herrmann, MD, *Associate Dean*
Colin Campbell, MD, *Assistant Dean for Student Affairs and Director of Admissions*
Charles L. Votaw, MD, *Assistant Dean for Curricular Affairs*
Ramon R. Joseph, MD, *Assistant Dean*
Herbert H. Spencer, MD, *Assistant Dean*
Otelio S. Randall, MD, *Assistant to the Dean*

Department Chairmen

Johannes A.G. Rhodin, MD, PhD, *Anatomy, as of Sept. 1, 1974*
Robert B. Sweet, MD, *Anesthesiology*
Minor J. Coon, PhD, *Biological Chemistry*
Park W. Willis, III, MD, *Cardiology*
Everett R. Harrell, Jr., MD, *Dermatology*
Chris J. D. Zarafonetis, MD, *Hematology*
James V. Neel, MD, *Human Genetics*
William D. Robinson, MD, *Internal Medicine*
Frederick C. Neidhardt, PhD, *Microbiology*
Russell N. DeJong, MD, *Neurology*
J. Robert Willson, MD, *Obstetrics and Gynecology*
John W. Henderson, MD, *Ophthalmology*
Walter P. Work, MD, *Otorhinolaryngology*
A. James French, MD, *Pathology*
William J. Oliver, MD, *Pediatrics*
Bert N. LaDu, MD, *Pharmacology, as of May 1, 1974*
James W. Rae, Jr., MD, *Physical Medicine and Rehabilitation*
Horace W. Davenport, PhD, *Physiology*
Neal A. Vanselow, MD, *Postgraduate Medicine, until June 1, 1974*
A.J. Silverman, MD, *Psychiatry*
Walter M. Whitehouse, MD, *Radiology*
Jeremiah G. Turcotte, MD, *Surgery*

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Robert F. Wilson, MD, *Assistant Dean for Detroit General Hospital Affiars*
Thomas Sullivan, MD, *Acting Director of Admissions*

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Gerhard C. Endler, MD, *Anesthesiology, Acting*
John G. Gaeth, PhD, *Audiology*
Ray K. Brown, MD, PhD, *Biochemistry*
Theodore Goldberg, PhD, *Community Medicine, Acting*
Alfred Edward, DVM, *Comparative Medicine*
Donald J. Birmingham, MD, *Dermatology and Syphilology*
Alegro J. Godley, MD, *Family Medicine, Acting*
Alexander J. Walt, MB, ChB, *General Surgery*
T.N. Evans, MD, *Gynecology and Obstetrics*
Noel R. Rose, MD, *Immunology and Microbiology*
Arnold M. Weissler, MD, *Internal Medicine*
John Gilroy, MD, *Neurology*
L. Murray Thomas, MD, *Neurosurgery*
William G. Fredrick, ScD, *Occupational and Environmental Health, Acting*
Vainutis Vaitkevicius, MD, *Oncology*
Robert Jampel, MD, PhD, *Ophthalmology*
Herbert E. Pedersen, MD, *Orthopedic Surgery*
Philip M. Binns, MB, ChB, *Otolaryngology, Acting*
Jacob L. Chason, MD, *Pathology*

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Bernard H. Marks, MD, *Pharmacology*
Joseph N. Schaeffer, MD, *Physical Medicine and Rehabilitation*
Walter H. Seegers, PhD, *Physiology*
Garfield Tourney, MD, *Psychiatry*
Kenneth Krabbenhoft, MD, *Radiology*
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Tom M. Johnson, MD, *Assistant Dean for Grand Rapids*
Thomas J. Cinque, MD, *Assistant Dean for Saginaw*
Dorothy M. Mulkey, MD, *Acting Assistant Dean for Flint*
Robert M. Daugherty, MD, PhD, *Director, Office of Curriculum Implementation*
Judith W. Krupa, PhD, *Director of Admissions*
J. Thomas Parmeter, PhD, *Assistant to the Dean for Evaluation*
James G. Lyon, MSW, MPH, *Assistant to the Associate Dean for Community and Clinical Programs*

Department Chairmen

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Bernard Gallin, PhD, *Anthropology*
Willis A. Wood, PhD, *Biochemistry*
John I. Johnson, PhD, *Biophysics*
William B. Weil, Jr., MD, *Human Development*
Scott N. Swisher, Jr., MD, *Medicine*
Philipp Gerhardt, PhD, *Microbiology and Public Health*
Thomas H. Kirschbaum, MD, *Obstetrics, Gynocology and Reproductive Biology*
Robert F. Langham, DVM, PhD, *Pathology, Acting*
Theodore M. Brody, PhD, *Pharmacology*
Francis J. Haddy, MD, PhD, *Physiology*
Norbert B. Enzer, MD, *Psychiatry*
John H. Wakeley, PhD, *Psychology*
Jay W. Artis, PhD, *Sociology*
Edward D. Coppola, MD, *Surgery*
John R. Shaver, PhD, *Zoology, Acting*

Directors

Sidney Katz, MD, *Office of Health Services Education and Research*
Ronald W. Richards, PhD, *Office of Medical Education Research and Development*
Christiana S. Blume, *School of Medical Technology, Acting*

MSMS Provides Funds for SAMA Chapters

MSMS has presented checks for $500 each to Student American Medical Association chapters at Michigan's three medical schools, at Wayne State University, Michigan State University and the University of Michigan.

The state society contributes annually to the SAMA chapters and also assists the SAMA Project for Medical Education and Community Orientation, which places students in summer educational programs throughout Michigan. Checks were sent to Karin Tansek at MSU, Mark Campbell at Wayne State and William Middleton at U-M, presidents of their respective SAMA chapters. All have participated in the SAMA-MECO program in the past.

Carnegie Program Wins Accreditation

The Carnegie Institute of Detroit, 200 Park Ave. Bldg., has been granted accreditation for its medical assisting program by the Council on Medical Education of the American Medical Association in collaboration with the American Association of Medical Assistants. Carnegie Institute offers a one-year certificate program.

acute gonorrhea*

This patient
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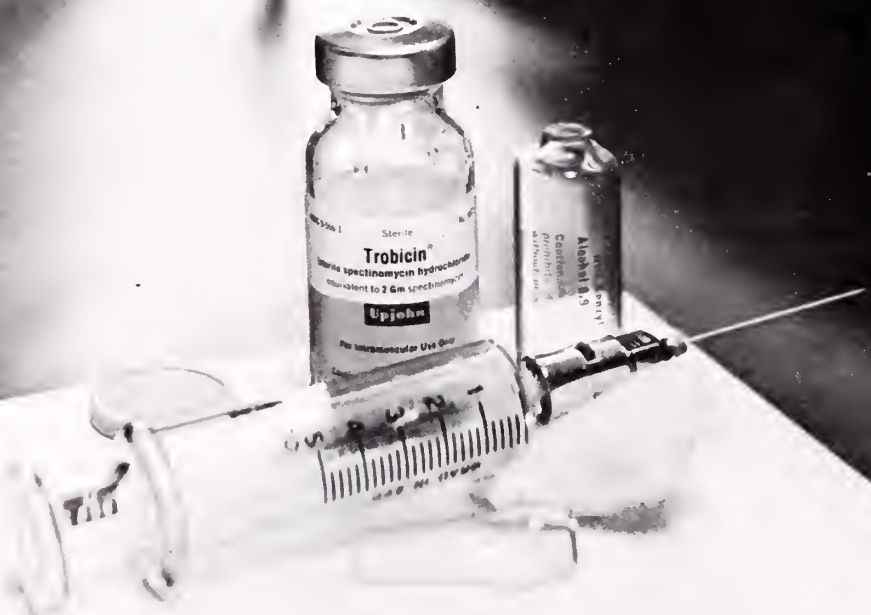
treatment.

It took just one short visit...



*Urethritis, cervicitis, proctitis when due to susceptible strains of *N. gonorrhoeae*

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Trobicin—The advantage of injectable therapy.
Once Trobicin is injected, treatment is usually complete; there can be no problems with patients sharing, skimping, skipping or forgetting medication.

Trobicin—The aspect of privacy.
There are no prescriptions to fill, no capsules to take. Neither family, friends nor co-workers need know or suspect the patient's problem.

Trobicin—Indication and dosage.
Spectinomycin is indicated only for use in acute urethritis and proctitis in the male and acute cervicitis and/or proctitis in the female when due to susceptible strains of *N. gonorrhoeae*. The usual dosage for Trobicin in adult males is 2 grams intramuscularly†; 4 grams intramuscularly in females.

Trobicin—Not effective for syphilis.
Trobicin is not effective for any stage of syphilis. Trobicin may mask or delay the symptoms of incubating syphilis. If concurrent syphilis is suspected, follow the patient serologically for at least 3 months. Patients with syphilis should receive adequate specific anti-syphilitic therapy with an appropriate antibiotic.
Trobicin is contraindicated in patients previously found hypersensitive to it.

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2 gm and 4 gm vials

sterile spectinomycin hydrochloride

Sterile Trobicin
Sterile Trobicin (spectinomycin hydrochloride) —For Intramuscular Injection:
2 gm vials containing 5 ml when reconstituted with diluent.
4 gm vials containing 10 ml when reconstituted with diluent.
An aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria gonorrhoeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between spectinomycin and penicillin.

Indications: Acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

Contraindications: Contraindicated in patients previously found hypersensitive to spectinomycin.

Warnings: Not indicated for the treatment of syphilis. Antibiotics used to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Patients should be carefully examined and monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected.
Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions should be observed with atopic individuals.
Clinical effectiveness should be monitored to detect evidence of development of resistance by *N. gonorrhoeae*.

Adverse reactions: The fallawing reactions were observed during the single-dase clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single- and multiple-dose studies in normal volunteers, a reductian in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25° C and use within 24 hours after reconstitution with diluent.
Male—Inject 5 ml intramuscularly for a 2 gram dose. Patients with ganarrheal practitis and patients being re-treated after failure af previaus antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.
Female—Inject 10 ml intramuscularly for a 4 gram dose.
How supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9%* w/v. Recanstitution yields 5 and 10 ml respectively with a concentratian af 400 mg spectinomycin per ml (as the hydrochloride). For intramuscular use anly.
Susceptibility Powder—far testing *in vitro* susceptibility of *N. gonorrhoeae*.
Cautian: Federal law prohibits dispensing without prescription.
For additional product information see your Upjohn representative or consult the package insert.

Upjohn

MED B-5-S (MBR-1)

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† For patients with gonorrheal proctitis and for patients in geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams is preferred.

Mediscene

April 24—Annual Legislative Day, MSMS Auxiliary, at Olds Plaza Hotel, Lansing, contact: Mrs. Robert J. Westerhoff, 2458 Maplewood, SE, Grand Rapids, Mich. 49506.

April 24-25—Annual Spring Conference, MSMS Auxiliary, at Hospitality Inn, Lansing, contact: Mrs. William J. Jones, president, 15839 Crescent Drive, Allen Park, Mich. 48101.

April 25-26—27th National Conference on Rural Health sponsored by the AMA Council on Rural Health at the Detroit Hilton Hotel, contact: Bond L. Bible, PhD, Department of Rural Health, AMA, 535 N. Dearborn St., Chicago, Ill. 60610.

April 25-28—Annual convention, American Association of Medical Assistants, State of Michigan, Detroit Hilton Hotel, contact: Virginia Doyle, 1484 Southfield Rd., Birmingham, Mich. 48009.

May 2-3—Annual session and scientific program, Michigan Heart Association, Cobo Hall, Detroit, contact: Marilyn Janes, Michigan Heart Association, 16310 12 Mile Rd., Southfield, Mich. 48076.

May 5—MSMS Council, Boyne Falls, contact: Warren F. Tryloff.

May 5-7—1974 Annual Session, MSMS House of Delegates, at Boyne Mountain Lodge, Boyne Falls, contact: Richard Campau, MSMS Headquarters.

May 6-10—Scientific session sponsored by the American Psychiatric Association in Cobo Hall, Detroit, contact: Walter E. Barton, MD, 1700 18th St. NW, Washington, D.C. 20009.

May 9-10—Seventeenth Annual Clinic Days of Children's Hospital of Michigan, postgraduate meeting on pediatric infectious diseases, cosponsored by the Wayne State University School of Medicine, contact: Adnan Dajani, MD, Children's Hospital of Michigan, Detroit Medical Center, 3901 Beaubien Blvd., Detroit, Mich. 48201.

May 10-11—Seventh Annual Cancer Symposium, on "Management of Ovarian Malignancy," sponsored by the Wayne State University School of Medicine in co-sponsorship with the American Cancer Society—Michigan Division and the Michigan Cancer Foundation, at Gordon Scott Hall, WSU Medical School, contact: Mrs. Dorothy Bewley, Cancer Symposium Registrar, 4160 John R St., Detroit, Mich. 48201.

May 11—Seminar on "Diseases of the Eye" sponsored by the Michigan Society of Pathologists at Michigan State University, East Lansing, contact: Robert Hendrix, MD, Department of Pathology, University of Michigan.

May 11—All Day Scientific Meeting of the Michigan Society of Anesthesiologists, Raleigh House, Southfield, contact: Thomas J. DeKornfeld, MD, Towsley Center, University of Michigan, Ann Arbor, Mich. 48104.

May 15—106th medical alumni reunion, Wayne State University School of Medicine, Gordon H. Scott Hall, WSU Medical Campus, Detroit, contact: WSU School of Medicine, 313/577-1495.

May 22-24—Annual forum for hospital trustees, administrators and medical chiefs of staff, sponsored by MSMS, MAOPS and the Michigan Hospital Association, at Boyne Mountain, contact: Herbert A. Auer, MSMS Headquarters.

May 24-25—Thirteenth Annual Kidney Disease Symposium sponsored by the Kidney Foundation of Michigan in cooperation with Henry Ford Hospital, in Buerki Auditorium, Detroit, contact Nathan W. Levin, MD, chairman, Kidney Foundation of Michigan, 3378 Washtenaw Ave., Ann Arbor, Mich. 48104.

June 8-9—Symposium in clinical neurotology, "Treatment of the Dizzy Patient," sponsored by Michigan State University College of Human Medicine at Kellogg Center, East Lansing, contact: Bruce Alderman, Kellogg Center, MSU, East Lansing, Mich. 48824.

June 12—MSMS Council, MSMS Headquarters, contact: Warren F. Tryloff.

June 22-27—AMA Annual Meeting, Chicago, contact: AMA, 535 N. Dearborn St., Chicago, Ill. 60610.

June 21-22—Meeting of Upper Peninsula Medical Society, Terrace Garden, Escanaba, contact: James R. Dehlin, MD, 8 S. 11th St., Gladstone, Mich. 49837.

July 6-10—Michigan Academy of Family Physicians Annual Meeting and Scientific Program, Park Place Motor Inn, Traverse City, contact: MAFP office, 933 Wing St., Plymouth, Mich. 48170.

July 25-28—Summer meeting of the Michigan Psychiatric Society, Inn on the Park Hotel, Toronto, contact: Charles W. Davenport, MD, University Hospital, Ann Arbor, Mich. 48104.

Aug. 1-3—MSMS Council, St. Clair Inn, St. Clair, contact: Warren F. Tryloff.

Sept. 25—MSMS Council, MSMS Headquarters, contact: Warren F. Tryloff.

Oct 9-10—1974 Annual MSMS Scientific Meeting, Sheraton-Cadillac Hotel, Detroit, contact: Helen Schulte, MSMS Headquarters.

Nov. 6—MSMS Council, MSMS Headquarters, contact: Warren F. Tryloff.

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MSMS Takes Key Role at AMA Conference

"Communications is not a function of the AMA, but the purpose of the AMA," declared AMA President Russell B. Roth, MD, at the 1974 AMA National Leadership Conference held recently in Chicago.

Donald N. Sweeny, Jr., MD, of Detroit, was a member of a panel discussing relationships between the physician, the hospital administrator and the hospital board.

The MSMS experiences with surveys to obtain factual information and to measure member attitudes were described at the AMA Seminar on Surveys by Herbert A. Auer, manager, MSMS Department of Communications.

The official representatives from the MSMS Council were Past President John J. Coury, MD; President-Elect Brock E. Brush, MD, and Robert C. Prophater, MD, vice chairman of The Council.

Also present were Thomas C. Payne, MD, chairman, MSMS Committee on Public Relations; Richard H. Gascoigne, MD, chairman, Special MSMS Task Force re Chiropractic; Robert E. Rice, MD, chairman, MSMS Committee on Governmental Medical Care Programs; Ned. I. Chalat, MD, president of Wayne County Medical Society; Francis P. Rhoades, MD, WCMS past president; Perry W. Greene, Jr., MD, president, Kent County Medical Society; Lewis E. Simoni, MD, president-elect, Genesee County Medical Society, and Orville W. Oughtred, MD, delegate to MSMS House for Macomb County Medical Society. Also present was Mrs. William S. Jones, president, MSMS Auxiliary.

Also present were Warren F. Tryloff, MSMS director; Bruce W. Ambrose, manager, MSMS Department of Government Relations; William McClimans, executive, Kent County Medical Society, and Norman Anderson, executive, Genesee County Medical Society.

The AMA conference featured speeches by Rep. Carl Albert, speaker of the U.S. House of Representatives, and Alvin Toffler, author of *Future Shock*.

FDA Pamphlets Tell Patients About Drugs

Three official Food and Drug Administration publications that reinforce the doctor's message to the patient regarding prescribed drugs are available free to MSMS members. These publications are made available through the cooperation of Diane M. Place, consumer affairs officer, for the FDA in Michigan.

The publications are:

"We Want You to Know What We Know About Prescription Drugs"

"We Want You to Know What We Know About Adverse Reactions to Medicines"

"We Want You to Know What We Know About Medicines Without Prescriptions"

To obtain one of each for study or to obtain small supplies, write to Diane M. Place, Consumer Affairs Officer, FDA, 1560 E. Jefferson, Detroit, Mich. 48207.

Mrs. Place, in offering the publications to MSMS members, told the MSMS Committee on Public Relations:

"It has been FDA's experience that more myths appear to surround drugs, both prescription and non-prescription products, than any other products regulated by the agency. These publications represent one approach to educating patients and dispelling at least some of these myths. Patients have confidence in the doctors who prescribe medicines for them. However, often the information given by the doctor to the patient is not completely understood or needs to be reinforced by an additional method. We are proposing that members of the Michigan State Medical Society consider distribution of one or all of the three publications when prescribing, recommending or dispensing drugs. This would reinforce the doctor's message to the patient, provide the patient with a written reminder and save the doctor's time."

The MSMS Committee on Public Relations will welcome comments from MSMS members about the experiences they have with these publications.

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An executive committee would be selected by the Board of Directors. There would be at least one dean or his designate, one non-university based physician educator and at least one osteopathic physician.

Professional Advisory Group

There would be a Professional Advisory Group (PAG) for each specialty or subspecialty discipline in which SHOTS had one or more participating training programs. At a minimum, each PAG would include one physician representative from each participating training program in the discipline involved. Representatives from other disciplines could be added at the discretion of the Board of Directors. Appointment of PAG members would be the responsibility of the Board of Directors following nomination by participating institutions. Each PAG would report to the Board of Directors through the Executive Committee of SHOTS.

Criteria for Participation in SHOTS

"Participation in SHOTS would be voluntary and would be on an institutional rather than an individual program basis. The Board of Directors would establish criteria for institutional participation in SHOTS, receive application from hospitals and other institutions offering house officer training programs, and determine which applicants met the established criteria.

"All of the house officer training programs conducted by an applicant institution would require approval by the Board of Directors to make the institution eligible for participation. If an existing program within a hospital was not approved initially, or was subsequently disapproved by the Board of Directors, the hospital would have the option of discontinuing that program, improving it sufficiently to regain approval, or withdrawing as an institution from participation in SHOTS. A participating institution could not conduct a program not approved by the Board of Directors and still participate in SHOTS. The standards set by the Board of Directors for house officer programs operated within the system must, at a minimum, meet the standards of the appropriate national accrediting body in allopathic or osteopathic medicine. It is recognized that the latter recommendation would result in separate criteria for approval of allopathic and osteopathic house officer programs in most cases."

Evaluation Process

The Board of Directors would establish a uniform system to evaluate both the house officers enrolled in participating training programs and the training programs themselves. The evaluation policies adopted by the Board of Directors would be administered by the Executive Director of SHOTS.

Financing

"It is proposed that financial support for the operation of SHOTS be provided by society through state government. This is a logical extension of the philosophy that health education and health training are basically societal responsibilities which in Michigan, as elsewhere, take the form of public support for medical schools, dental schools and a variety of other health education and training programs. Since the production of a qualified physician requires in all cases some form of house officer training beyond medical school, it is appropriate that the philosophy which provides for public support of undergraduate medical education be extended to include internships, residencies, and clinical fellowships."

The advantages of such a program include:

1. It would standardize the quality of all graduate training programs in the state of Michigan.
2. It would control the types of training programs and insure adequate numbers of graduates in areas with deficiencies.
3. It would place the support of graduate medical education on the state and relieve the insurance carriers from these costs to which they object. (e.g., Pennsylvania).

Disadvantages of such a system might include:

1. It would increase the governmental control of medical education with all of its bureaucrats.
2. It would decrease the control of medical education programs by individual community hospital medical staffs. This would be relinquished to the Physician Advisory Groups.

All of the membership is encouraged to become knowledgeable with this proposal and consider what it might do for health care in Michigan.

Editor's Note: The MSMS House of Delegates is expected to discuss the SHOTS proposal at meetings May 5-7 when a report from the Ad Hoc Committee on Graduate Medical Education will be considered. The committee was authorized by delegates at their meeting last fall.

New higher interest rate on U.S. Savings Bonds.

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Take stock in America. It's in your interest.

Take stock in America.

Join the Payroll Savings Plan.

In Memoriam

Russell A. Allen, MD
Adrian

Russell A. Allen, MD, 54, a family physician in Adrian for 28 years died Feb. 26 in St. Joseph Hospital, Ann Arbor. Doctor Allen was associated with the Heffron Clinic in Adrian for five years before establishing his own practice there. He had served as Adrian College physician since 1947. A graduate of the University of Michigan Medical School, Doctor Allen served in the armed forces during World War II.

Gerhard H. Bauer, MD
Ann Arbor

Gerhard H. Bauer, MD, 62, an orthopedic surgeon in Ann Arbor, died Feb. 25 in St. Joseph Mercy Hospital, Ann Arbor. He was chief of staff at the hospital from 1969 to 1971 and chairman of the orthopedics department from 1959 to 1972. Doctor Bauer was clinical associate professor of medicine at the University of Michigan Medical School, his alma mater, and also had been on the medical faculty of Johns Hopkins University.

Doctor Bauer was trained as an artist and architect before entering medicine and frequently exhibited his paintings. He particularly liked to paint scenes of Iceland, where he was stationed in the army medical corps during World War II. He was a past president of the Washtenaw County Medical Society and the Michigan Orthopaedic Society.

Elden C. Baumgarten, MD
Grosse Pointe Woods

Elden C. Baumgarten, MD, 80, of Grosse Pointe Woods, a retired surgeon, died March 10 in Deaconess Hospital, Detroit, where he had served as chief of surgery before his retirement. He also had served on the staffs of St. John and Cottage Hospitals. Doctor Baumgarten, a graduate of the University of Michigan Medical School, was a past president of the Detroit Academy of Surgeons.

Luciano Celori, MD
Marquette

Luciano Celori, MD, 47, an anesthesiologist and family physician in Marquette since 1959, died March 5 in Marquette General Hospital North. A native of Italy, Doctor Celori was graduated from the University of Rome medical school and completed internship and residency programs at Lincoln Hospital in New York City and Mercy Hospital in Canton, Ohio.

Lawrence S. Fallis, MD
Pompano Beach, Fla.

Lawrence S. Fallis, MD, 80, former chief surgeon at Henry Ford Hospital, Detroit, died March 18 at his home in Pompano Beach, Fla. Doctor Fallis was educated at the University of Michigan and joined Ford Hospital in 1925 after completing graduate work at St. Bartholomew's Hospital, London, and the University of Edinburgh, Scotland. He retired as chief surgeon in 1966 but continued as a consultant until 1971.

Thomas J. Greene, Jr., MD
Detroit

Thomas J. Greene, Jr., MD, 45, a Detroit thoracic and cardiovascular surgeon, died March 17 in an automobile accident in Detroit. Doctor Greene was graduated from Meharry Medical College in 1954, interned at Wayne County General Hospital and completed residencies at Herman Kiefer Hospital and the University of Minnesota and Veterans Hospitals in Minneapolis. Doctor Greene was the only Michigan physician serving on the Department of Health Education and Welfare's advisory council on PSROs. At the time of his death, Doctor Greene was serving as president of the Wolverine State Medical Society.

Doctor Greene was on the staffs of seven Detroit area hospitals and a member of the surgery faculty at the Wayne State University School of Medicine. He was a diplomate of the American Board of Surgery and a fellow of the American College of Abdominal Surgery.

Geza Kovacs, MD
Caro

Geza Kovacs, MD, 68, of Caro, died Feb. 6 at the Caro Regional Center, where he was a member of the medical staff. Doctor Kovacs was born in Hungary and received his medical education there. He practiced in Europe until coming to the United States in 1957. He moved to Caro in 1959 and formerly was associated with the Caro State Hospital and the Caro State Home and Training School.

Carl W. Swanson, MD
Cedar Mountain, N.C.

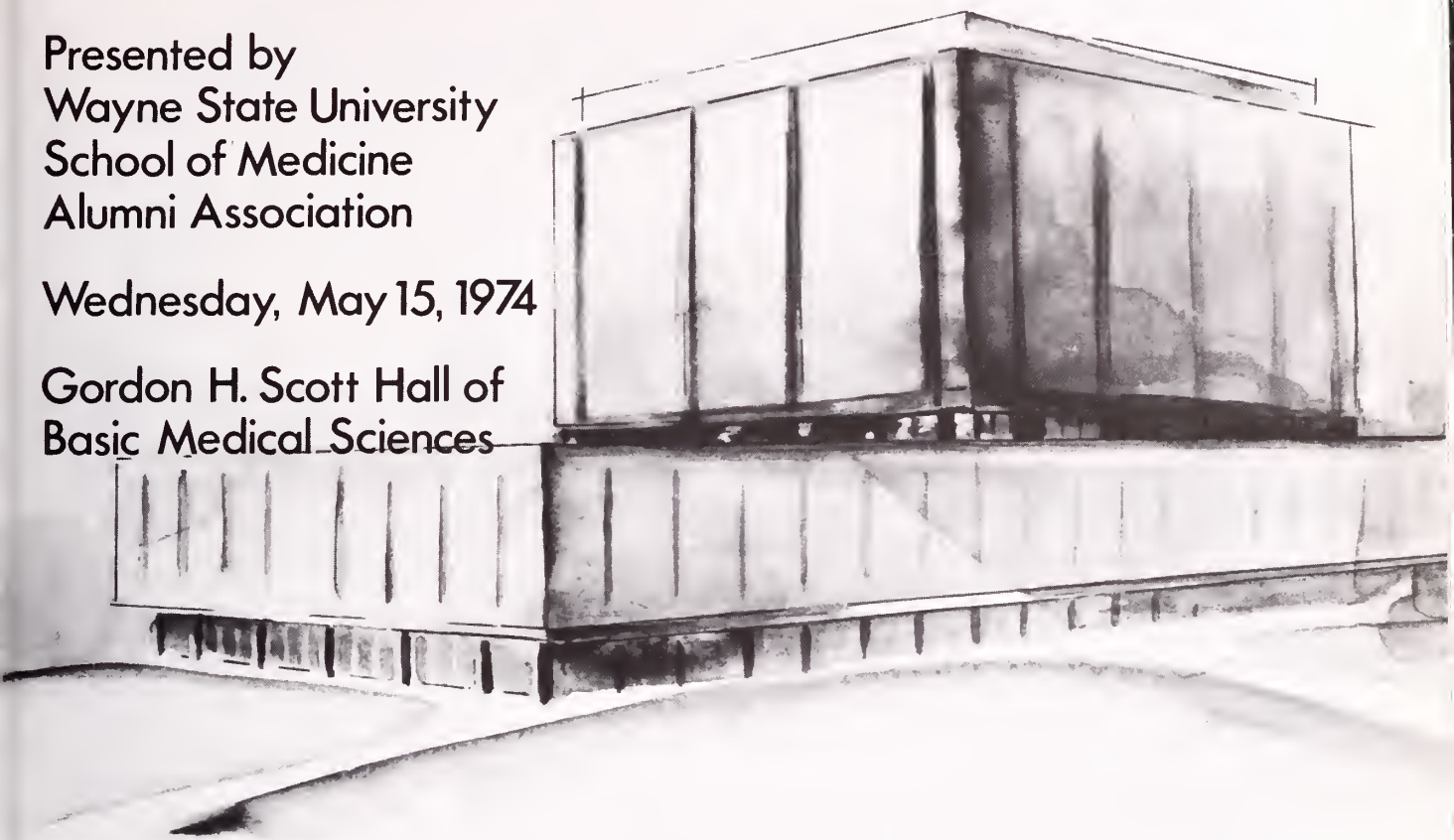
Carl W. Swanson, MD, 72, of Cedar Mountain, N.C., a family physician in the Grosse Pointe area for 42 years before his retirement, died March 11 in Brevard, N.C. Doctor Swanson was a graduate of the University of Michigan Medical School and had been on the staffs of Jennings and Bon Secours Hospitals before his retirement.

106th Medical Alumni Reunion

Presented by
Wayne State University
School of Medicine
Alumni Association

Wednesday, May 15, 1974

Gordon H. Scott Hall of
Basic Medical Sciences



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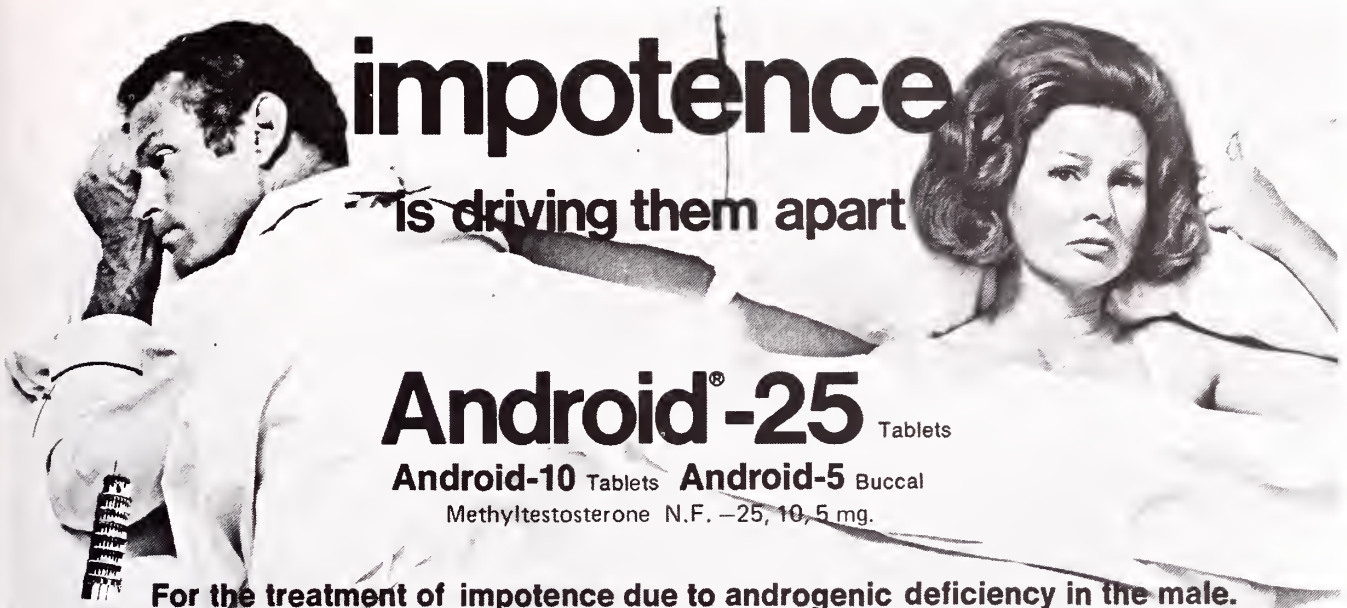

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Beating the Deadline

By Herbert A. Auer, Executive Editor

Is any physician serving as mayor of a Michigan city? There are at least two wives of physicians presiding now at city council meetings. **Mrs. Barbara Waters** is mayor at Petoskey and **Mrs. James M. Davis** is mayor at South Haven. Are there others?

Luebert Docter, MD, of Grand Rapids, hits the newspapers from time to time, whenever some columnist discovers there is a Doctor Docter in Michigan. *Detroit Free Press* Columnist Mark Beltaire recently featured Doctor Docter. Luebert always tells the newsmen he is "glad my mother never named me Horace."

One of the moving forces behind the several special shows at the Detroit Institute of the Arts for Physicians, in connection with the MSMS Annual Sessions, has left for Toledo. **Alfred Golden, MD,** active on several WCMS and MSMS committees, will direct the labs at St. Vincent Hospital and Medical Center. His wife, Libby, is a talented artist.

If you ask **Harold Bowman, MD,** president-elect of the Kent County Medical Society, for a calling card, he is apt to give you one of his Hal and Sally Bowman cards. The card says: "Wanted: John Rogers Groups and related memorabilia." An interesting hobby.

When complaints are raised about the rising costs of drugs, I recall the Parke, Davis & Company application in 1968 for a new drug, Ketalar, which required 72,200 pages of facts for the FDA. Twenty years earlier, Parke Davis filed 73 pages of information to obtain the license for Benylin Expectorant.

Jack S. DeTar, MD, the MSMS "Foremost Family Physician" in 1949 and a former speaker of the MSMS House of Delegates, has retired after 42 years of family practice in Milan.

Michigan Medicine has carried a number of articles in the past eight years by **Jose Llinas, MD,** Lansing psychiatrist, who will leave in July to direct a community mental health program in Gainesville, Fla. Doctor Llinas also wrote considerable copy for the Michigan Psychiatric Society *Newsletter* and the Ingham County Medical Society's *Medicina.*

The "golden shovel award" was given this year by the Lenawee County Medical Society to personable, outgoing **Maurice M. Galliani, MD,** of Adrian. The doctors all sit at the awards banquet—hoping they won't get the award!

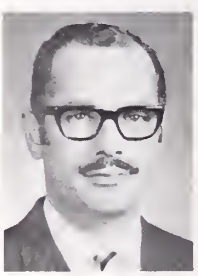
Ministers at a recent Lansing conference received advice on how to work with cancer patients and their families from **H. Marvin Pollard, MD,** Ann Arbor, a past national president of the American Cancer Society.

This page will appear each month with news items "on the human side" gathered from correspondence, meetings, conversations and tips we hope you will send in from time to time.

Dr. Docter

Dr. Bowman

Dr. DeTar



Dr. Galliani

Dr. Pollard

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Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. In editorials, the views expressed are those of the writer and not necessarily official positions of the society.

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President's Page

Do We Need a Young Doctor Section?

Doctor Masters

Let me this month float another idea to improve our medical societies.

My proposal is that MSMS and the component societies should establish a "Young Doctor Section" as an integral part of our structure.

By doing this, physicians under 35 years of age, or under 40, would be afforded more opportunities to assume responsibilities and provide leadership. True, no one is stopping them now and several are moving up in MSMS as well as in some of the components. But some of these doctors have voiced their concerns about their difficulties in becoming really active.

May I invite the younger doctors to react to my proposal. Are you interested?

Does the idea have merit especially in the larger component societies?

I'd welcome letters from doctors of all ages.

Our MSMS past president, John J. Coury, MD, held special regional meetings for physicians under 40 in Kalamazoo, Lansing and Mt. Clemens during his term as president. At all three locations, young physicians said they did want to contribute, they did want to change some aspects of medical society traditions and they did feel frustrated in their efforts.

One professional society which already involves a good percentage of its younger members is the State Bar of Michigan.

I feel I can make this personal reference to the young attorneys because I sensed their enthusiasm and interest when I spoke to the Delegate Assembly of the State Bar on March 2.

The potential of young people is documented by the effective public service provided in Michigan for 50 years by the Michigan Jaycees and their local components.

There is no reason why one of the components could not experiment with a "Young Doctors Section" that could have its own meetings, study issues, send representatives to board meetings to report and could really get involved. I encourage any interested component president to take the initiative to at least study this idea. Please contact me if I can offer any counsel.

Are there shortcomings to this proposal? I'm sure there are, the possibility of power plays, of friction. But the apparent plus-factors outweigh the negative possibilities, I believe.

This proposal, I feel, is just one of many evolutionary changes I believe MSMS and the components should consider as we move forward better to serve the profession and the public.

Brooker L. Masters, MD

MSMS Action

Council Approves Expansion of Society's Department of Government Relations

The MSMS Council, meeting March 13 in East Lansing, approved a Legal Affairs Committee proposal to expand the society's liaison with government agencies and legislators substantially. The proposal, which was referred to the House of Delegates Ways and Means Committee after Council acceptance, would mean the addition of two new professional employees to the society's staff.

The expanded Department of Government Relations staff would devote itself both to added dealings with government and to facilitation of physician and component society involvement in public affairs.

Two Bills Opposed

The Council also approved recommendations from the Legislative Policy Committee that MSMS oppose a Michigan bill that would require the Medical Practice Board to establish mandatory continuing education for physicians and another that would alter the chiropractic licensing act.

John W. Grigg, MD, of Bay City (standing right) chairs new MSMS Committee on Professional Liability Problems established recently to seek solutions to malpractice insurance problems. Above Doctor Grigg meets with (seated from left) Glenn E. Moore, MD, of Flint; Arthur J. Johnson, MD, of Detroit; A. B. Eisenbrey, MD, of Detroit, and William H. Johnson, MD, of Kalamazoo, and (standing left) A. Stewart Kerr, MSMS legal counsel.

The Council heard a report from James D. Fryfogle, MD, chairman of the Medicaid Liaison Committee, that 90 per cent of Michigan physicians now are participating in Medicaid. MSMS President Brooker L. Masters, MD, reported that Professional Standards Review Organization area designations recommended by MSMS component societies had been accepted by the federal Department of Health, Education and Welfare.

Study on Records Asked

The Council asked the Liaison Committee with the State Bar to study recommendations for a position statement on confidentiality of medical records because of complexity of the question. The MSMS Committee on Scientific and Education Affairs has proposed the following position statement:

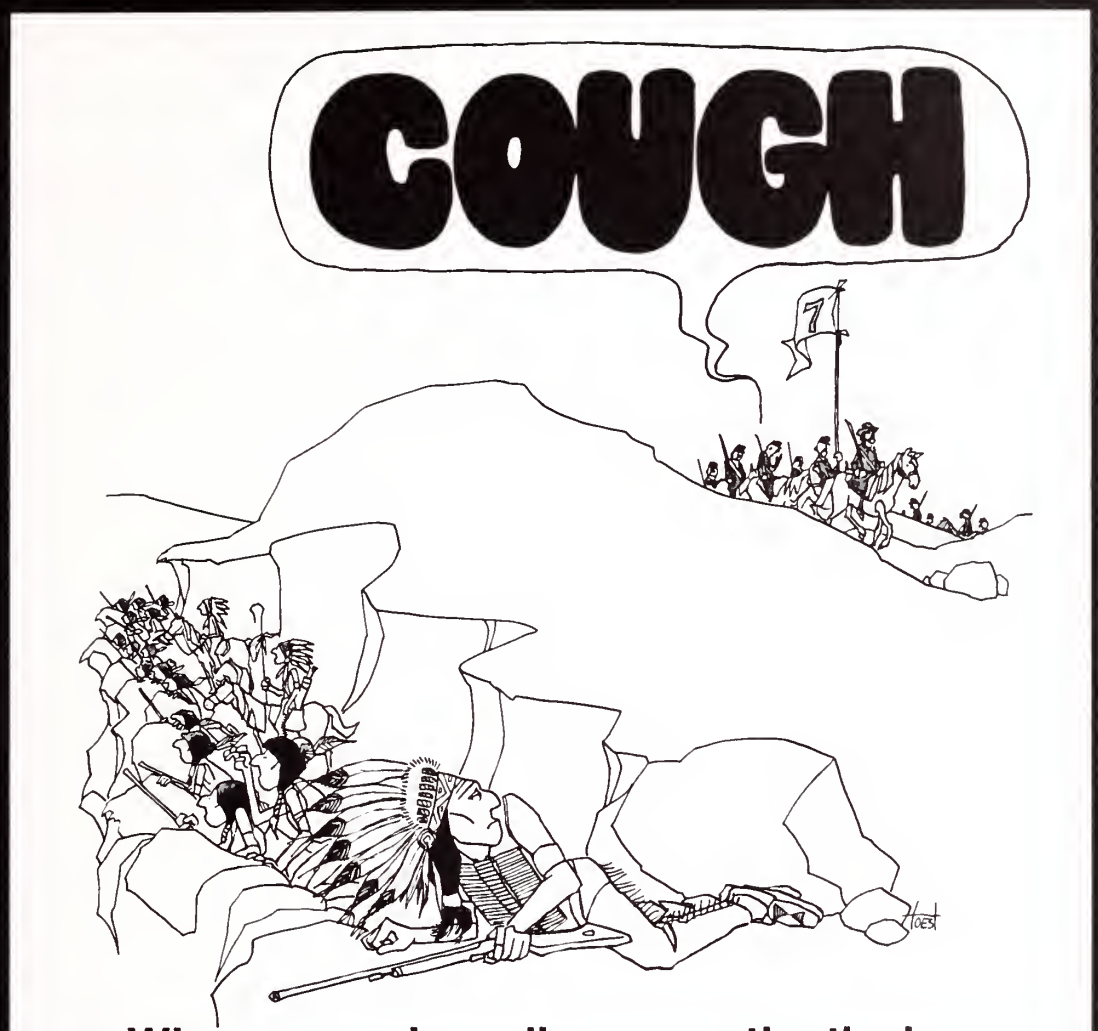
1. The hospital will not release medical records to any third persons until such third persons tender an original, executed patient consent release, currently dated.
2. Audits by insurance carriers shall be done in the hospital, or otherwise through a summary only, of the relevant hospital records.

A request that the Council support a Michigan Hospital Association position statement on reimbursement for chronic renal disease under Medicare was deferred until after anticipated AMA pronouncements on the subject are made.

The Council discussed the proposed Statewide House Officer Training System for graduate medical education at length, then agreed to delay recommendations until further committee study.

Brock E. Brush, MD, MSMS president-elect, was named to the MSMS Board of Managers for a

(Continued on page 248)



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Letters

Michigan Medicine invites reader comment on articles and other material appearing in the publication and on matters of general interest to physicians. The editors reserve the right to delete material from letters for publication. Letters must be signed for consideration for publication, but names will be withheld on request. Please address communications to Letters to the Editor Column, Michigan Medicine, 120 W. Saginaw St., East Lansing, Mich. 48823

Can Medicine Reconcile Technology and Economy?

To the Editor:

The letter of Brooker Masters, MD (President's Page, *Michigan Medicine*, January, 1974) raises some questions for us to think about.

Doctor Masters says "old fashioned ideas are not good enough to meet today's level of medical expertise—the best quality medical care means new computer technology." Yet every patient today is sick and tired of being constantly run through the "new computer technology." They all have fond memories of old fashioned family doctors.

Doctor Masters says "20-30 per cent of all x-ray examinations are unnecessary." And yet this is the very application of the "computer technology."

Doctor Masters asks "How productive, really, is the pre-operative chest x-ray?" Well, the "routine" chest got rid of tuberculosis.

Doctor Masters says "conscientious radiologists deplore the percentage of "negative" GI Series or skull exams they report." Yet the AMA and

(Continued on Page 278)

MSMS Provides Services to Psychiatric Group Under New Contract

MSMS is now providing executive-accounting-secretarial services to the Michigan Psychiatric Society (MPS) on a contract basis.

MSMS and MPS have signed a management plan contract. Kenneth E. Pitts, MD, MPS president, points out that the specialty society now will be able "to utilize the experiences of the MSMS professional staff and facilitate the sharing of services and other common resources to minimize costs and to maximize effectiveness."

Helen A. Schulte, chief of the MSMS division of scientific affairs, has been assigned as the part-time executive secretary for MPS by Warren F. Tryloff, MSMS director. Robert J. Roney, MSMS controller, will handle the accounting and IBM aspects of the MPS operations.

This new MSMS service to a specialty society, according to Robert M. Leitch, MD, chairman of the MSMS Council, "will increase the interchange of information and eliminate some duplication of work pertaining to membership, scientific programs, legislation and other matters." The contract assures confidentiality of internal matters and the promotion of the individual identity of each organization.

Judy Marr, former managing editor of *Michigan Medicine*, will work on a part-time contract basis to write and produce the MPS Newsletter under the direction of an editorial committee.

MSMS has offered management and secretarial services to the Michigan specialty societies in recent years, and informal discussions are underway with other specialty organizations. MSMS provided management services on a contract basis during the formative years of the American College of Emergency Physicians, which now has its own staff and headquarters in East Lansing.

one-year term. Doctor Brush also is to represent MSMS at the May 16-17 meeting of the Minnesota Medical Association.

Committees Named

Council Chairman Robert M. Leitch, MD, announced a number of committee appointments. H. Richard Henderson, MD, Detroit, was named chairman of the Committee on Rehabilitation of Sick Physicians. Members include William T. Davison, MD, Port Huron; Don W. McLean, MD, Southfield; John P. Newton, MD, Grand Rapids; Frank H. Power, MD, Traverse City; K. L. Ramadas, MD, Detroit; H. A. Raskin, MD, Southfield; Melvin L. Selzer, MD, Ann Arbor; Russell F. Smith, MD, Whitmore Lake, and I. Richard Weiss, MD, Kalamazoo.

Members of the Liaison Committee with the Michigan Medical Practice Board, to serve with the chairman, Robert M. Stow, MD, Lansing, whose appointment was announced earlier, are Jaime V. Aragones, MD, Rochester; Robert M. Daugherty, MD, East Lansing; Donald H. Kuiper, MD, Lansing; Charles L. Seifert, MD, Battle Creek; Thomas J. Setter, MD, Mt. Clemens; Franklin L. Troost, MD, Holt, and John J. Coury, MD, Port Huron, advisor.

James Copping, Jr., MD, of Port Huron, was appointed to the Highway Injury Committee, and Robert W. Talley, MD, and Henry J. Vanden Berg, MD, both of Detroit, to the Michigan Cancer Coordinating Committee.

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Scientific Articles

Kveim Antigen: *Test, Quest and Request*

By Earl J. Rudner, MD, and Paul A. Goodman, MD, Detroit

The Kveim test is a valuable adjunct in supporting the diagnosis of sarcoidosis. Unfortunately, Kveim antigen is not readily available and requires individual preparation. The following describes our experiences in the clinical evaluation of this test material.

Materials and Methods

Kveim antigen is a crude 10% suspension of particulate sarcoid tissue. The source of antigen usually is a human spleen surgically removed for treatment of hypersplenism secondary to systemic sarcoidosis. Prior to removal, the operating room personnel must be warned not to place the specimen in preservative. The entire specimen is aseptically frozen. Histologic confirmation of sarcoid granuloma must be demonstrated before preparation of the antigen. The specimen must first show no evidence of routine bacteria, virus or myobacterium growth. Either ultra sound or mechanical grinding of the specimen is used to produce a 10% saline suspension. A few drops of phenol is added as a preservative.[1] The resultant particulate suspension should again be microscopically examined for small granulomata formation.

The test is performed by intradermal injection of 0.1-0.2 cc of well-shaken suspension into the forearm and indicated in the clinical record. Autoclaved ink may also be added to the suspension. The local tatoo aids in later detection.[2] A saline control should be injected into the contra lateral forearm. Skin biopsy of all test sites six weeks after injection is obligatory. Kveim reactivity requires 4-6 weeks for maturity. Systemic steroids should be withheld as a dosage of 20 mg of prednisone equivalents will depress reactivity.[3]

Following several frustrating attempts, the authors prepared a suitable antigen according to the above Chase-Siltzbach technique.[1] Twenty-one patients were selected for testing from 1969-72 according to a uniform protocol. All skin biopsies were interpreted by the junior author and/or Amir Mehregan, MD, dermatopathologist, Wayne State University School of Medicine, *(Figures 1, 2)*. Patients were divided into two groups:

Group I: Previously confirmed sarcoidosis by histologic examination of lymph nodes, liver or lung.

Group II: Clinically highly suspicious of sarcoidosis and/or suggestive roentgenographic findings without prior histologic confirmation.

Results

Eight patients were tested in Group I and seven showed positive reactivity (88 per cent). Of the 13 patients tested in Group II, eight showed positive Kveim reactivity (61 per cent). The remaining five patients all were diagnosed as having sarcoidosis on the basis of accepted clinical criteria or roentgenographic interpretation. Reactive test sites usually showed elevation or induration at time of examination; however, all test sites were biopsied since Kveim reactions may occasionally only be detected microscopically. One individual was clinically observed to have no Kveim reactivity at the end of six weeks. The patient had been on systemic steriods for several months. Eighteen months later, she was re-examined and a definite indurated nodule histologically confirmed was excised from the antigenic test site.

Discussion

The most difficult problem confronting the physician wishing to perform the test is obtaining a source of antigen, since a central source is not commercially available. Hospital pharmacies and laboratories not infrequently will receive requests for test material. The shelf life of individual Kveim preparations varies. Nelson and Schwimmer found the specificity and reactivity of ten separate

(Continued)

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preparations to range from seven months to seven years.[4]

For several years an international group has studied Kveim reactivity using common antigenic material.[5] An overall incidence of 57 per cent positive reactivity of 2,038 subjects is reported. Positive tests were greater in cases less than two years in duration. Forty-eight per cent of the patients tested were initially asymptomatic. Retesting with Kveim antigen three to five years later shows a loss of reactivity in almost 50 per cent of the cases.[6]

The international study indicated erythema nodosum as the most common presenting sign (78 per cent) in the Kveim positive subjects. Roentgenographic evidence of enlarged pulmonary hilar nodes especially when associated with pulmonary mottling were important diagnostic findings.

The active fraction of the Kveim antigen is probably a protein and Kveim reactivity possibly resides in subcellular particles of the test suspension as determined by sucrose gradients and electron microscopic monitoring.[7] Siltzbach has characterized Kveim reactivity as a "novel type of particularly long delayed hypersensitivity."[7]

A recent report has concluded that Kveim reactivity is related to the degree of lymphadenopathy of diverse etiology and not to duration or activity or a particular illness.[8] The validity of these conclusions has been challenged by investigators with larger clinical series.[9]

Conclusion

At the present time, the Kveim test should be considered as an adjunct in differentiating sarcoidosis from other granulomatous and chronic non-granulomatous conditions. It is particularly helpful when other organ biopsy material is not available. If the clinician performs the test properly and realizes the limitations inherent in the preparation of the antigen, the test will have a more meaningful value.

Figure 1: Positive Kveim test skin biopsy. Non-caseating granulomatous reaction in lower 2/3 of dermis. H & E 50X.

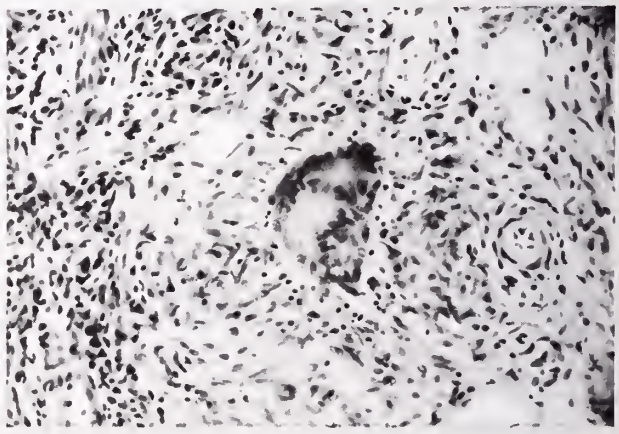

Figure 2: Positive Kveim test skin biopsy showing well defined epithelioid cell tubericle formation. No caseation is present. H & E 300X.

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Survival on Patients with Obstructive Coronary Arteriosclerosis: *Surgical Versus Medical Management*

By Walter H. Janke, MD; Ing-Sei Hwang, MD, and Leandro F. Africa, MD
Heart Institute of Michigan, Flint

Saphenous aorto coronary bypass provides immediate blood flow to the ischemic myocardium distal to obstructive coronary lesions. A question which remains to be answered is whether this results in any increase in long term survival.[1] In an attempt to elucidate this problem the present study was performed utilizing the patient population referred to the Heart Institute of Michigan for management of obstructive coronary arteriosclerosis.

Materials and Methods

All patients on whom coronary angiograms had been performed at the Heart Institute of Michigan between December, 1969, and June, 1972, were selected for evaluation. Only patients considered to be potential candidates for re-vascularization had been studied. Coronary angiograms were reviewed by cardiovascular fellows not involved in the management of these patients. Four hundred ten patients had one or more areas of obstruction on one or more of their coronary arteries with distal run off suitable for bypass surgery. Subsequently, it was determined which patients had had surgery. This constituted 219 patients. One hundred ninety-one patients had not had surgery. The average follow-up on the surgical group was 18 months. The non-surgical group was 20 months. A questionnaire was sent to the group of patients who did not have surgery. On the majority it was found that they had decided against it of their own will or on the advice of their family physicians often without having had the benefit of a surgical consultation.

Age and sex distribution in both groups are shown in Table 1.

Symptomatology and Results *(Table 2)*

Impending infarction: Twenty-three patients on the surgical group had impending infarction. There have been no early or late mortalities in this group. In the group followed conservatively two out of seven patients expired.

Angina at rest: Eighty-five patients with angina at rest had surgery. Hospital mortality was one patient. Four additional patients died during the follow-up period for a total early and late mortality of five patients. On the non-surgical group there were 31 patients with angina at rest. Mortality in this group was six patients.

Angina on exercise: Angina on exercise was present in 54 patients on the surgical group. Hospital mortality was one patient and late mortality one patient for a combined mortality of two patients. On the non-surgical group there were 92 patients

TABLE I

Age and Sex Distribution

		Surgical	Non-Surgical
30-40		6	10
40-50		61	56
50-60		106	92
60-70		44	31
70-80		2	2
	Total	219	191
Male		186	162
Female		33	29
	Total	219	191

TABLE II

	Surgical		*Non-Surgical*	
	Patients	Early & Late Mortality	Patients	Early & Late Mortality
Impending infarction	23	-	7	2
Angina at rest	85	5	31	6
Angina on exercise	54	2	92	10
Congestive heart failure	27	-	39	3
Arrhythmias	4	-	2	-
Valve replacement	6	-	-	-
Asymptomatic	20	-	20	5
Total	219	7 (3.2%)	191	26 (13.6%)

(Continued)

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with angina on exercise. Mortality in this group was ten patients.

Congestive heart failure: In our institution congestive heart failure is not considered to be a contraindication for surgery as long as there are one or more arteries with adequate run off distal to areas of obstruction. There were 27-patients in this category who had surgery. There was no hospital or late mortality in this group. On the non-surgical group out of 39 patients in congestive heart failure three patients died.

Arrhythmias: Arrhythmias were the predominant symptom in four patients on the surgical group and two patients on the non-surgical group. There was no early or late mortality in either one of these groups.

Associated valvular surgery: On six patients valvular replacement was the primary indication for surgery, an incidental coronary bypass being, also, performed. There was no mortality in this group.

Asymptomatic patients: Forty patients were asymptomatic at the time of their coronary angiography. These patients had all had either a previous history of a myocardial infarction or a fleeting episode of angina. All of them at the time of hospitalization for angiography denied to have any symptoms and were able to normally exercise without shortness of breath or angina. Twenty of these patients had surgery. There was no hospital or late mortality in this group. In contrast, again, 20 patients did not have surgery. Five of these patients or 25 percent expired during the follow-up period.

Discussion

A truly randomized study to elucidate the question of long term survival on medical versus surgical management of patients with obstructive coronary arteriosclerosis does not appear to be feasible. Even if of all patients referred to us, we select at random one patient for surgery and one for conservative management this would not be adequate. In all likelihood, we would be comparing groups of patients with entirely different anatomical lesions.[2-3] On the other hand, it would be impossible to randomize patients with identical anatomical obstructions.[4] If the blockages were on a similar area, the run off, the dominance of the artery or the status of the remaining vessels may not be the same. In view of this, in our study we started by selecting patients on whom coronary angiograms had shown that they could be helped by surgery, that is, patients who had complete or incomplete areas of obstruction on their coronary arteries with distal segments visualized directly or through collaterals where a bypass graft could be performed.

Subsequently, it was determined which patients had not had surgery. The majority of them had decided against it on their own will or on the advice of their family physicians, often without a surgical consultation having been obtained. None of these patients had medical contraindications for surgery. On this group of patients our study showed a very significant difference in survival. On the surgical group out of 219 patients hospital as well as late mortality was seven patients or a total mortality of 3.2 per cent. On the non-surgical group out of 191 patients the mortality was 26 patients or 13.5 per cent.

Summary

Study of 410 patients with obstructive coronary artery lesions amenable to surgical treatment is presented. Two hundred nineteen patients followed for an average of 18 months had surgery. Hospital mortality was two patients and late mortality five patients for a total mortality of 3.2 per cent. One hundred ninety-one patients followed for an average of 20 months did not have surgery. Mortality in this group was 26 patients for a total mortality of 13.5 per cent. We feel this study shows that with a low initial hospital mortality coronary bypass surgery is the treatment of choice in patients with obstructive coronary arteriosclerosis with suitable run off.

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Perinatal Tips

By Paul M. Zavell, MD

The following case from the files of the Wayne County Medical Society Perinatal Mortality Study Committee is presented as an aid in continuing education.

Maternal

This was the 4th born of a 32 year-old G IV, P II (III) A+ white mother. A previous child died at birth but the cause is not known. Nineteen days after her E.D.C. the amniotic membranes ruptured spontaneously but labor failed to ensue despite a slow pitocin drip. About 36 hours after the membranes ruptured fetal bradycardia of 90/minute was noted. An emergency C-section was quickly performed despite the fact that the mother had a temperature of 102.4° (thought to be due to cystitis or pyelitis since her urine showed many pus cells and some clumps). At C-section the amniotic fluid was noted to be foul smelling and meconium stained. Estimated blood loss was 500 cc. Medications used at Labor and C-section Delivery were Demerol 50 mgm and Seconal 100 mgm. Weight gain was 25 pounds and only prenatal vitamins with iron were used during pregnancy. With the use of ampicillin the mother had an uncomplicated recovery after C-section and she went home on the seventh post-operative day.

Fetal

This 7 lb. 5½ oz. white female infant was severely depressed at birth, cyanotic and covered with meconium. Despite suction of nose and throat and emptying of the stomach the Apgar score at one minute was only 2. The infant was intubated needing oxygen and assisted breathing for 30 minutes before she was able to breathe on her own. During this period she was given 10 cc of $NaHCO_3$ via the umbilical vein and I.M. Caffeine Na Benzoate. The impression was "R.D.S. and possible aspiration pneumonia." Respirations were 36/minute, irregular with apneic spells and marked intercostal retractions. Heart rate was 100/minute. A chest x-ray taken at this time was read as "normal lung with heart size at upper limits of normal but no gas in the G.I. Tract." In the nursery besides oxygen in an isolette, an I.V. of 10% G/W was now started. Studies done in the first six hours of life included: Glucose (72), Hgb (16.8 gm), Hct (55), WBC (54,400), PMN (30), Bd (10), Lymph (59), Eos (01). At about 14 hrs. of age frequent jerky movements of the extremities began and continued intermittently until about 36 hours of age. Studies done then were Calcium (9.8), Phosphorous (6.5), a Blood culture and an L.P. The spinal fluid was Xanthochromic with 783 Rbc, 44 Wbc, (91% Lymph and 9% PMN), Protein 73, Glucose 75 and Chloride 146. She remained slightly cyanotic despite oxygen. At this time Aq. Penicillin 100,000 U IV q 12 h and Kanamycin 25 mgm IM q 12 h were started. The diagnosis was now changed to "cerebral anoxia and neonatal seizures secondary to anoxia and possible intrauterine infection." At 24 hours of age the infant vomited twice. Culture of this vomitus revealed E. Coli (later shown sensitive to Ampicillin). Intermittent jerking with some generalized seizures continued despite use of Phenobarbital and Valium. At about 36 hours of age 100 mgm of Pyridoxine was given and all jerking and seizures then ceased. The blood and spinal fluid cultures done at 14 hours were now reported as negative. Cyanosis and respiratory distress seemed to disappear at 48 hours of age. However by this time the abdomen was noted to be somewhat distended and urine output was now very scanty (especially during the prior 12 hours). New studies now obtained showed K = 4.7, Na = 127, Cl = 91, CO_2 = 16, BUN = 50, Blood gases of Ph = 7.48, PCO_2 = 25,

(Continued)

Doctor Zavell is chairman of the Perinatal Mortality Study Committee of the Wayne County Medical Society and a member of the Neo-Natal and Hospital Care Committee, Michigan Chapter, American Academy of Pediatrics.

Monthly Surveillance Report

Cases of Certain Diseases
Reported to the Michigan Department of Public Health
For the four-week period ending March 29, 1974

MICHIGAN DEPARTMENT OF PUBLIC HEALTH

	1974 This 4-Week Period	1973 Same 4-Week Period	1974 Total To Above Date	1973 Total Same Date	Total Cases for 1973
Rubella	128	268	402	535	2,001
Cong. Rubella Syndrome	0	0	0	1	4
Measles	399	734	875	1,239	4,552
Whooping Cough	0	3	14	25	86
Diphtheria	0	0	0	0	0
Mumps	856	550	2,664	1,811	5,042
Scarlet Fever & Strep Sore Throat	5,456	2,434	15,186	7,081	24,467
Tetanus	0	0	1	0	2
Poliomyelitis (paralytic)	0	0	0	0	0
Hepatitis	350	306	1,067	999	3,872
Salmonellosis (other than S. typhi)	75	52	299	152	795
Typhoid Fever (S. typhi)	0	2	2	3	14
Shigellosis	66	32	276	129	623
Aseptic Meningitis	8	8	34	30	434
Encephalitis	6	15	10	34	163
Meningococcic Meningitis	7	4	15	11	54
H. Influenza Meningitis	9	12	36	26	89
Tuberculosis	122	124	328	380	1,380
Syphilis	219	367	861	1,142	4,328
Gonorrhea	2,441	2,251	8,067	7,216	31,128

Information can be supplied by the local health department on the local incidence of disease.

Maurice Reizen, M.D., Director
Michigan Department of Public Health

*corrected totals

PERINATAL TIPS/Continued

PO_2 = 104, O_2 Sat_2 = 98 and repeat chest x-ray of "atelectasis of right lung, left lung hazy with slight cardiac enlargement." X-rays of abdomen were "unremarkable" and a catherized urinalysis was grossly bloody. There was no real change in the next 12 hours. However, at about 60 hours of age the infant again became cyanotic with return of respiratory distress and subcostal retractions. Soon thereafter a generalized convulsion occurred followed by disappearance of all vital signs. External cardiac massage then resulted in return of the heart beat, and the infant was maintained on a respirator for another 36 hours until death (confirmed by flat EEG).

The final clinical diagnosis was "placental dysfunction with cerebral hypoxia resulting in brain damage."

An autopsy was done that revealed only a large I.V. septal defect and pulmonary atelectasis and congestion.

Perinatal Committee Comments

1. Where there has been a prior loss of an infant and when the pregnancy is not progressing normally (premature rupture of membranes, 19 days after E.D.C., failure of pitocin drip), it is not wise to wait until fetal complications present themselves to deliver the infant. Early C-section here would have been indicated.
2. When foul smelling and meconium stained amniotic fluid is present, culture of this at the time of birth might be very helpful in later management of the infant.
3. Cultures of blood, CNS, etc. should be done and then appropriate antibiotics (penicillin and Kanamycin) should be started as soon after birth as possible when conditions exist (premature rupture of membranes, foul smelling meconium stained amniotic fluid, etc.) that indicate possible fetal infection is occurring or can occur. Treatment can be stopped later if all cultures are negative and the infant shows no symptoms. However, by early treatment an infant may thus be saved from death from sepsis, menengitis, etc.
4. There is little or no justification for use of Caffeine Na Benzoate when depression of the infant is present. If this is thought to be due to drugs, use of *Narcan* is suggested (without danger of respiratory depression developing secondary to the use of the medication).
5. When an infant is born under complicating conditions or early develops severe symptoms, consideration of transfer to an N.I.C.U. should be seriously weighed.

Redskin Remedies:

Contributions of the American Indian to Patent Medicines

By Howard G. Wilcox, MD, Salt Lake City, Utah

In its early days, the American practice of medicine was often a brutal profession. The ministrations of bleeding, cupping, cathartics, leeches, surgery without anesthesia—these were what the physician proffered. Surely there had to be a better way. And quick to reveal their "better way" were the patent medicine peddlers, "the toadstool millionaires," as designated by Oliver Wendell Holmes.* They offered a pleasant way to stave off the Grim Reaper and restore health.

There were several reasons for the success of patent medicines. The infirm had the remedy as available as his town druggist or local post office. Its purchase was swift, not requiring a prolonged wait to see the physician. The only expense was for the panacea, paying a physician's fee was unnecessary. The nostrum was often more palatable than prescribed pharmaceuticals. And the spectrum of diseases claimed to be cured was inclusive enough to satisfy the needs of even the most dedicated hypochondriac. As an example, Mexican Herbs of Joy, concocted in Boston, was touted as an "Elegant Remedy" guaranteed to cure "Billiousness, Sick Headache, Costiveness, Jaundice, Heart Disease, Diabetes, Torpid Liver, Impure Blood, Urinary Difficulties, Piles, Wakefulness, Rheumatism, Malaria, Bad Complexion" as well as miscellaneous ailments.

A goodly supply of varied patent medicines thus became an essential part of many households.

Now the term "patent medicine" did not imply that the United States Patent Office had assigned a patent to the nostrum. To the contrary, seldom did any two consecutive batches of the remedy have the same constituents. And to register the formula in a public document was the last thing most compounders wished to do. Rather, the term "patent" as applied to medicines was a carry over from Mother England. The ruling English monarch had for generations granted "patents of royal favor" to the confectioner, tailor, mediciner and other providers of products and services to the royal family. When such medicines bearing the royal patent then began to be exported to the colonies, those concoctions bearing the mark of royal approval were particularly highly sought after. Before long, the term was generally applied to all non-prescribed remedies.

*"Somebody buys all the quack medicines that build palaces for the mushroom, say rather, the toadstool millionaires."[1]

Figure 1: In 1859, this noble warrior stood aloof from the battle in the background to dignify Wigwam tonic.

It soon became evident to the nostrum peddlers that a simple generic product name had no charisma. An exotic or mysterious name would have an aura suggesting strange and wonderful properties of the patent medicine. In the 1800s, Americans were becoming aware of legends about remote geographic regions—legends of longevity, health and therapeutics. And many patent medications adopted names to lend this aura to their products. As Young stated, "The hardy soul

(Continued)

From the Salt Lake Veterans Administration Hospital and the Department of Medicine, University of Utah College of Medicine. First appeared in the January, 1974, issue of the Rocky Mountain Medical Journal. Reprinted with permission in this issue of Michigan Medicine.

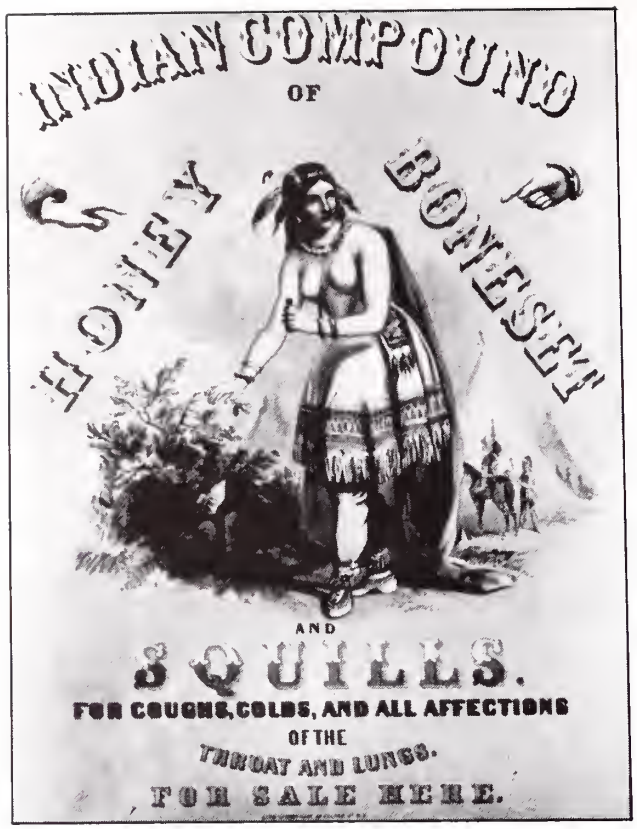


Figure 2: This lovely Indian maiden is collecting Boneset for a panacea for "all affections (sic) of throat and lungs." Boneset was effective in inducing vomiting, but that's about all.

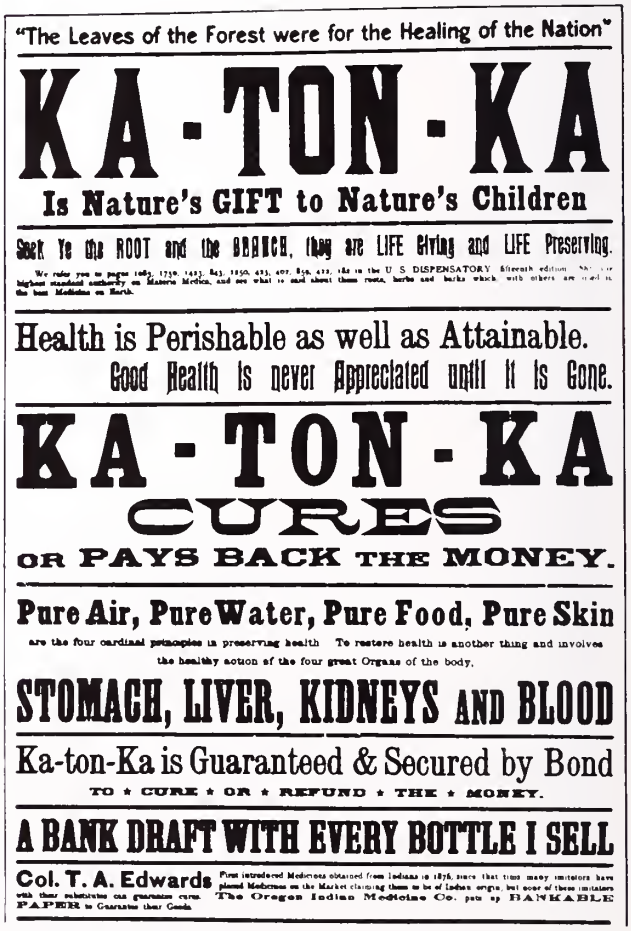
could dose himself around the world . . . (with) an international therapeutic arsenal." Who could fail to benefit from such exotic medications as Hayne's Arabian Balsam, Brasilian Bitters, Carey's Chinese Catarrh Cure, Hoffland's Greek Oil, Wyncoop's Iceland Pectoral, Mecca Compound or Hart's Swedish Asthma Medicine?

A major source of exotic promotion, however, had been nearly overlooked. The American Indian was generally regarded as a mysterious and noble creature in whom was embodied these awesome characteristics of health and healing. And because of an ancient doctrine (and its corollary), the Indian was an even more likely person to be associated with local therapeutics.

The Doctrine of Signatures was one of the oldest tenets of folk medicine. It stated that God in His wisdom had provided *natural* cures for the ailments of man and had provided clues to help man in his search for them. Thus, for example, cracked walnut shells were useful for head injury and teas made from burrs or thistles were helpful for sharp abdominal pain. The corollary of this doctrine held that these remedies were provided in the regions where the diseases were encountered. Thus, one looked for cures for the ague (malaria) not in the Arctic, but rather in the jungles where the ailment flourished.

Who, then, would be the logical person apt to know the most about God's pharmacopoeia in nature? The American Indian! It was even conceded that Indians were "as able physicians as any in Europe." A medical almanac of the 1800s suggested that the Noble Savage was to be trusted even more than the educated physician. It stated that the Indian ". . . is a better curative agent than the youth who, after a dozen medical lectures or so, is given authority as an MD to try his hand on anybody who comes along." Another nostrum pamphlet stated, "The Art of Healing had its origin in the Woods, and the Forest is still the best Medical School."

Thus was born the alliance between the American Indian and the peddler of patent medicines, and it developed to a most profitable and flourishing alliance, at least to those who concocted the remedies. Hiawatha hawked a hair restorer, Pocahontas touted a bitters, and many anonymous Indians graced advertisements for


"The Leaves of the Forest were for the Healing of the Nation"

KA-TON-KA

Is Nature's GIFT to Nature's Children

Seek Ye the ROOT and the BRANCH, they are LIFE Giving and LIFE Preserving.

We refer you to pages 1082, 1710, 1432, 843, 1850, 433, 407, 836, 433, etc in the U. S. DISPENSATORY Eleventh edition, the highest standard authority on Materia Medica, and see what it said about these roots, herbs and barks which with others are used in the best Medicine on Earth.

Health is Perishable as well as Attainable.

Good Health is never Appreciated until it is Gone.

KA-TON-KA

CURES

OR PAYS BACK THE MONEY.

Pure Air, Pure Water, Pure Food, Pure Skin

are the four cardinal principles in preserving health To restore health is another thing and involves the healthy action of the four great Organs of the body,

STOMACH, LIVER, KIDNEYS AND BLOOD

Ka-ton-Ka is Guaranteed & Secured by Bond

TO * CURE * OR * REFUND * THE * MONEY.

A BANK DRAFT WITH EVERY BOTTLE I SELL

Col. T. A. Edwards First introduced Medicines obtained from Indians in 1876, since that time many imitators have placed Medicines on the Market claiming them to be of Indian origin, but none of these imitators with their substitutes can guarantee cure. The Oregon Indian Medicine Co. puts up BANKABLE PAPER to Guarantee their Goods.

Figure 3: Ka-Ton-Ka not only guaranteed its curative properties, but gave the consumer a capsule medical education, replete with U.S. Dispensatory pharmacologic references.

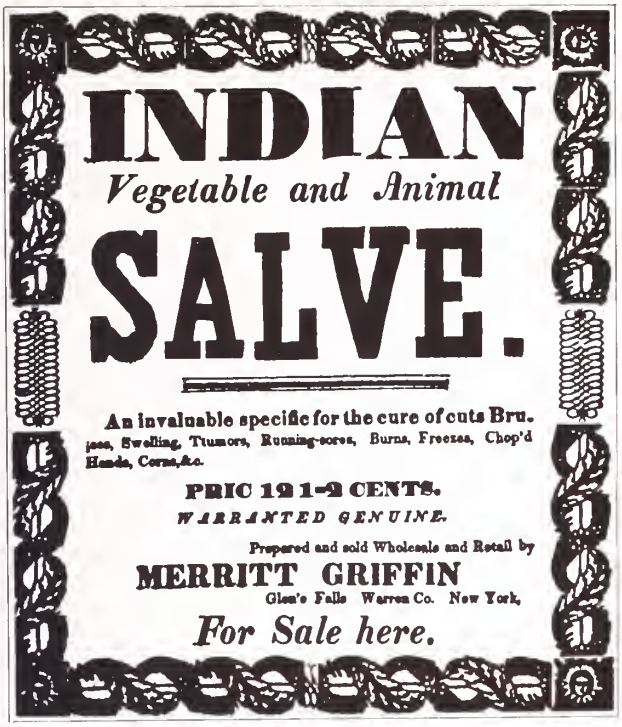
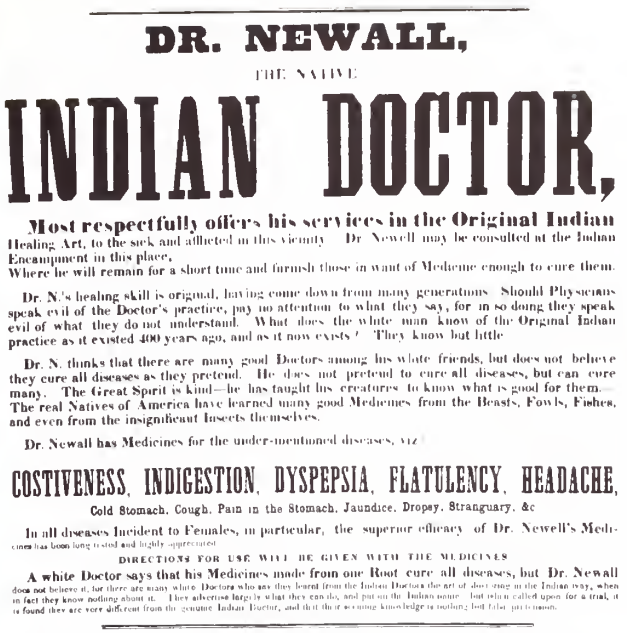

INDIAN
Vegetable and Animal
SALVE.
An invaluable specific for the cure of cuts Bru.
Swelling, Tumors, Running-sores, Burns, Freezes, Chop'd Hands, Corns, &c.
PRIC 12 1-2 CENTS.
WARRANTED GENUINE.
Prepared and sold Wholesale and Retail by
MERRITT GRIFFIN
Glen's Falls Warren Co. New York,
For Sale here.

Figure 4: Merritt Griffin capitalized on the legendary rapidity of healing of wounds of the Indian hide to hawk his nostrum.


DR. NEWALL,

THE NATIVE

INDIAN DOCTOR,

Most respectfully offers his services in the Original Indian Healing Art, to the sick and afflicted in this vicinity. Dr. Newell may be consulted at the Indian Encampment in this place,
Where he will remain for a short time and furnish those in want of Medicine enough to cure them.

Dr. N.'s healing skill is original, having come down from many generations. Should Physicians speak evil of the Doctor's practice, pay no attention to what they say, for in so doing they speak evil of what they do not understand. What does the white man know of the Original Indian practice as it existed 400 years ago, and as it now exists? They know but little.

Dr. N. thinks that there are many good Doctors among his white friends, but does not believe they cure all diseases as they pretend. He does not pretend to cure all diseases, but can cure many. The Great Spirit is kind—he has taught his creatures to know what is good for them. The real Natives of America have learned many good Medicines from the Beasts, Fowls, Fishes, and even from the insignificant Insects themselves.

Dr. Newall has Medicines for the under-mentioned diseases, viz:

COSTIVENESS, INDIGESTION, DYSPEPSIA, FLATULENCY, HEADACHE,

Cold Stomach, Cough, Pain in the Stomach, Jaundice, Dropsy, Stranguary, &c

In all diseases Incident to Females, in particular, the superior efficacy of Dr. Newell's Medicines has been long tested and highly appreciated.

DIRECTIONS FOR USE WILL BE GIVEN WITH THE MEDICINES.

A white Doctor says that his Medicines made from one Root cure all diseases, but Dr. Newall does not believe it, for there are many white Doctors who say they learnt from the Indian Doctors the art of doctoring in the Indian way, when in fact they know nothing about it. They advertise largely what they can do, and put on the Indian name, but only called upon for a trial, it is found they are very different from the genuine Indian Doctor, and that their seeming knowledge is nothing but false pretension.

Figure 5: It was hardly just that all the profits of Redskin Remedies be taken by the Paleface. "Doctor" Newall sought to rectify this. He cleverly pointed out that even white doctors who peddle Indian medicines "know nothing about it." If it's gonna work, you gotta get if from an Indian doctor!

wondrous remedies *(Figures 1 and 2)*. Other Indian remedies were advertised by less picturesque but more educational means *(Figures 3 and 4)*.

If the Indian charisma could be successfully exploited in print, imagine how much more effective it would be to have a personal presentation by a Native American *(Figure 5)*. The initial successes were sporadic. But this was probably because the promotional aspects were handled by amateurs. However, two occurrences were to be amalgamated to produce what would become the most indelible contribution of the Indian to American medical care.

The first of these was the reintroduction of white Americans to the American Indian in the 1880s. This was most successfully done by expert impressarios such as "Buffalo Bill" Cody. The "new" Americans could thus become acquainted with the mysterious native denizen of America—the Indian. As they made their Eastern excursions, Buffalo Bill's Wild West Shows consistently drew large crowds of the curious. The second occurrence was the evolution of traveling medicine shows. These combined entertainment with a patent pharmaceutical sales pitch. The interaction between the local Rubes and hawkers lasted only a day or two, and the show was again on its way. A major component of their success was analyzed by Victor Holmes,[2] ". . . they (the public) like to pay a little for a tonic and an evening's entertainment rather than pay a lot to a doctor who gives you no fun at all."

The amalgamators of Indian therapeutics and theatrics were a Connecticut Irishman and a Texan. John E. Healy, better known as "Doc Healy," had made his initial plunge into patent medicines with his Liver Pad, linen gauze stuffed with sawdust and red pepper, the latter to give a tingling sensation to the skin over which it was applied. Charles Bigelow, again better know as "Texas Charley," had served his promotional apprenticeship with other touring shows.

The mated imaginations of Doc Healy and Texas Charley produced, then, the "granddaddy" of all Indian medicine shows, the Kickapoo Indian Medicine Company and its famous Kickapoo remedy, Sagwa *(Figure 6)*. A portable teepee encampment provided the scenario. The frenetic show consisted of Indian war dances, whoops and tom-tom beating and other native entertainment. Finally, an impassioned history and testimonial for Sagwa was delivered in his native tongue by one of the Kickapoos. The message was translated for the spectators by a Paleface shill. While the translation was stated to be faithful to the original, this might be open to slight doubt, since the

(Continued)

The Kickapoo Indian Medicine Co.,
With their Medicine Men, Bucks and Squaws are now
Encamped at Culbertson, for Two Weeks.
Giving a Free Entertainment Each Evening
What the People Say!
Kickapoo Indian Sagwa
Nature's Remedy
Roots Herbs Barks
Blood, Life, and Strength Making
OUR KICKAPOO FAMILY MEDICINE CHEST
KICKAPOO INDIAN OIL
KICKAPOO INDIAN SALVE
KICKAPOO INDIAN COUGH CURE
KICKAPOO INDIAN WORM KILLER
Sold by All Druggists
Call and consult the Indian Medicine Men at their camp, if you are sick and suffering. Advice and Consultatio
free. If they can help you they will tell you so

Figure 6: Sagwa was the principal product hawked by the enormously successful Kickapoo Indian Medicine Company.

speaker's fellow Indians often convulsed with laughter at what was translated as a very serious statement. "Sagwa! Made from roots, barks, gums, leaves, oils and berries. Gathered by little Kickapoo children from God's great laboratory—the fertile fields and vast forests. Sagwa!" In addition to Sagwa, as they passed through the crowd the vendors offered Kickapoo Oil, Salve, Cough Cure and Worm-Killer. None was cheap. The Worm-Killer, for example, sold for the then-considerable price of five dollars.

So great was the success of the Kickapoo Indian Medicine Show that Healy and Bigelow had up to one hundred troupes touring at any given time. It thus became necessary to advertise for "genuine Indians." To be a Kickapoo was not a requirement *(Figure 7)*. In fact, there is no reliable documentation that a real Kickapoo was *ever* hired for the Kickapoo Indian Medicine Company. Myriad other Indian Medicine Shows copied the Kickapoo format and most encountered significant success.

In the early 1900s, however, the patent medicine scene began to be disturbed by vocal and powerful critics. The 1906 Pure Food and Drug Acts, championed by Doctor Harvey Wiley, was the outstanding step in the direction of reform. Among its provisions, it held that no false or misleading claims could be made about medical products. The end of the "quack" era of patent medicines was at hand. But during its heyday, the mystique of the American Indian had been fully exploited in a most colorful period of American medical history.

References

1. Young JH: *The Toadstool Millionaires.* Princeton, NJ, Princeton University Press, 1961.
2. Carson G: *One for a Man, Two for a Horse: A Pictorial History, Grave and Comic, Of Patent Medicines.* New York, Bramhall House, 1961.

Acknowledgment

My appreciation is extended to Mr. Paul Smith for his assistance in preparing the illustrations.

FIFTH YEAR. IMMENSE SUCCESS
OF THE
Kickapoo Indian Medicine Company,
HEALY & BIGELOW, Agents.
For the Summer season we are now organizing 25 advertising Indian medicine camps, each party to consist of six genuine Indian medicine men in their traits, customs and habits in the Far West. Three first-class specialty performers who do not depend on music for their act; one able and convincing medicine talker or lecturer as manager for each party. The outfit to consist of six Indian tepees or wigwams, large twenty-foot portable-covered stage, Gales' Patent Beacon Lights. Balloon ascensions every day and fireworks at night. The greatest advertising attraction in the world. $100,000 capital invested. The whole community for miles turn out to visit our genuine Indian camps or villages to buy Indian Sagwa, Indian Oil, Indian Worm-killer and Kickapoo Buffalo Salve. Doctors and performers of experience in the above line can always find steady work the year round with us; also performers who can work out of doors at free open-air entertainments, and are willing to make themselves generally useful, can find steady employment at good salary. Honesty and sobriety demanded from all.
Address JOHN E. HEALY, 87 West street, New York City.

Figure 7: To provide the casts of "Genuine Indians" for the large numbers of simultaneous touring troupes, reservations were scoured, Wild West shows were raided and advertisements such as this were placed in periodicals.

Commentary

Conservatism Versus Radicalism in the Diagnosis of Cervical Cancer

By J. H. Ahronheim, MD, Jackson

The introduction of the science of exfoliative cytology in the early diagnosis of cervical cancer as a routine "Pap" smear is, without doubt, the prime factor which, during the relatively recent past, has led to the dramatic reduction in mortality of a cancer which once was one of the most dreaded malignant tumors in women. Since its inception some 30 years ago, gynecologic cytology has undergone a number of changes. Our views on what represents a cancer cell have been modified, and the cytologists have learned to understand that not every atypical cell is a cancer cell. In the beginning of the cytologic era, many cytologists have let their enthusiasm over this remarkable diagnostic tool get the better of them and may have gone overboard on reporting a malignancy where there was no malignancy.

While we have become more conservative over the years, we still have a long way to go before reaching a stage of relative perfection. Consequently, the treatment is still not to the best welfare of the patient. There are several reasons why this is so. One is the degree of the cytologist's competence. Here, the crux of the matter is not the overtly negative smear or the overtly positive smear; it is even not the doubtful smear which presents some, but not all, criteria of malignancy. It is the smear with the non-cancerous but unusual cell, one which one would not see in the ordinary negative smear. This cell would not be a problem with the few true experts in cytology, who are apt to know what kind of cell it is; it would not be a problem with the great majority of competent pathologists, who may not know what kind of cell it is, but will know what cell it is not, namely, a cancer cell.

Dr. Ahronheim

Doubts Cause Concern

The dilemma is with the cytological neophyte who knows neither. In his commendable desire not to miss anything, he reads more out of the smear than there is. His doubts about this particular cell will, of course, cause concern to the physician and to the patient and may result in a surgical procedure which would not have been performed had the smear been seen by a more experienced person.

Another problem lies in the manner in which cytological smears are usually reported. Papanicolaou's classification of Class I, II, III, IV and V was designed for the purpose of getting away from the dry, not too informative negative-positive type of reporting. Actually, not only has it contributed little to the clinician's understanding of

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Michigan Medicine's new Commentary page will offer physicians and others the opportunity to express opinions on issues in medicine. Contributions are invited and should be submitted to Commentary, *Michigan Medicine*, 120 W. Saginaw St., East Lansing, Mich. 48823.

The views expressed here are those of the author and do not represent positions of the Michigan State Medical Society or opinions of the editors of *Michigan Medicine*.

The author is editor of Iateria, the bulletin of the Jackson County Medical Society, and a past president of the Jackson County Medical Society. He is former chief pathologist at Foote Hospital in Jackson.

AMA President-elect Malcolm C. Todd, MD, (right) is welcomed to Michigan by Brooker L. Masters, MD, MSMS president, during the California physician's recent appearance before the Kent County Medical Society in Grand Rapids.

Around Michigan

Kent Society Fetes Next AMA President

Grand Rapids area physicians learned about American Medical Association plans and goals for the coming year March 12 when Malcolm C. Todd, MD, AMA president-elect, was a special guest of the Kent County Medical Society. Doctor Todd, a Long Beach, Calif., general surgeon, will step into the AMA presidency in June.

He has played a major role in the AMA's efforts to alleviate shortages of physicians and allied health professionals. He explained these efforts to reporters at a televised news conference held during his visit to Grand Rapids.

AMA President-elect Malcolm C. Todd, MD, answers questions for reporters at televised news conference during visit to Grand Rapids to speak before physicians and guests at a meeting of the Kent County Medical Society.

Component Societies Select Leaders

Most of the Michigan State Medical Society's 56 component societies have selected officers who will serve during the remainder of 1974, some continuing into 1975. Following is a reference list of county society officers. For additional copies of the list, please contact the MSMS Department of Communications and Professional Information.

Society	President	Secretary	President-elect
Allegan	L.A. LaGuttuta, MD Allegan	Van O. Keeler, MD Otsego	R.L. Plagenhoef, MD Plainwell
Alpena, Alcona, Presque-Isle	William K. Lehmann, MD Alpena	Peter Aliferis, MD Alpena	Bruce A. Ohmart, MD Alpena
Barry	Larry L. Blair, MD Hastings	Oscar DeGoa, MD Hastings	
Bay, Arenac, Iosco	Robert C. Prophater, MD Bay City	William J. Stansell, MD Bay City	John T. Geneczko, MD Bay City
Berrien	Samuel H. Gould, MD Benton Harbor	E.D. Silvernale, MD Berrien Center	S.G. Cilella, MD Niles
Branch	Chieh-Cheng Wu, MD Coldwater	V.P. Reddy, MD Coldwater	William J. Stewart, MD Union City
Calhoun	Charles J. Ryan, MD Battle Creek	Peter J. Stephens, MD Battle Creek	Anne F. Norgan, MD Battle Creek
Cass	Justo de Varona, MD Dowagiac	F.A. Aquino, MD Cassopolis	Henry V. Guzzo, MD Dowagiac
Chippewa, Mackinac	Dale Scott, MD Sault Ste. Marie	Earl S. Rhind, MD Sault Ste. Marie	Thomas B. Mackie, MD Sault Ste. Marie
Clinton	Victor L. Sheline, MD Ithaca	George W. Bennett, MD Elsie	James M. Grost, MD St. Johns
Delta, Schoolcraft	James R. Dehlin, MD Gladstone	Mary L. Cretens, MD Escanaba	William A. LeMire, III, MD Escanaba
Dickinson, Iron	Paul R. Trump, MD Iron Mountain	Dale R. Shampo, MD Iron Mountain	
Eaton	Eber B. Sherman, MD Eaton Rapids	Thomas A. Kelly, MD Charlotte	
Genesee	Walter Z. Rundles, MD Flint	F. W. VanDuyne, MD Flint	Lewis E. Simoni, MD Flint
Gogebic	Florian J. Santini, MD Ironwood	John R. Franck, MD Wakefield	Donald L. Davidson, MD Bessemer
Grand Traverse, Leelanau, Benzie	Charles R. Williams, MD Traverse City	Arthur F. Dundon, MD Traverse City	Kenneth H. Musson, MD Traverse City

(Continued)

Society	President	Secretary	President-elect
Gratiot	Wilmer M. Rutt, MD Alma	Richard J. Remsberg, DO Alma	Keith L. Stackhouse, MD Alma
Hillsdale	Arthur J. Stein, MD Hillsdale	Charles T. Vear, MD Hillsdale	
Houghton, Baraga, Keweenaw	Kenneth L. Repola, MD Laurium	Howard E. Otto, MD Hancock	John A. Stroube, MD L'Anse
Huron	Charles S. Elliott, MD Pigeon	Robert A. Willits, MD Elkton	C. Clark Herrington, MD Bad Axe
Ingham	Howard C. Comstock, MD East Lansing	Donald R. McCorvie, MD East Lansing	Bernard H. Smookler, MD East Lansing
Ionia, Montcalm	Carl M. Hansen, MD Stanton	Charles E. Stevens, MD Greenville	Joseph Kopchick, MD Muir
Isabella, Clare	John W. Coles, MD Mount Pleasant	Frank D. Johnson, MD Mount Pleasant	Gilbert D. Klickstein, MD Mount Pleasant
Jackson	Robert E. Medlar, MD Jackson	Bruce F. Knoll, MD Jackson	Edward E. Weddon, MD Stockbridge
Kalamazoo	Thomas R. Berglund, MD Portage	George J. Hoekstra, MD Parchment	Almon L. Schut, MD Kalamazoo
Kent	Perry W. Greene, Jr., MD Grand Rapids	Anna H. Broecker, MD Grand Rapids	Harold E. Bowman, MD Grand Rapids
Lapeer	Harry R. Zemmer, MD Lapeer	Leon R. Boruch, MD Lapeer	Isak O. Berker, MD Davison
Lenawee	William C. Gilkey, MD Adrian	Ronald E. Isley, MD Blissfield	Harold D. Ocamb, MD Adrian
Livingston	Thomas A. Barton, MD Howell	Stanley L. Hoffman, MD Howell	Phillip E. Schmitt, MD Howell
Luce	Donald K. Barstow, MD Engadine	Robert D. Gibson, MD Newberry	E. Chang Ping, MD Newberry
Macomb	William C. Wyte, MD Mount Clemens	Ronald J. Sables, MD Mount Clemens	Leland C. Brown, MD Mount Clemens
Manistee	Vickers C. Hansen, MD Manistee	Roman R. Knoblich, MD Manistee	Richard L. Novack, MD Manistee
Marquette, Alger	Henry J. Barsch, MD Marquette	Thomas G. Rumney, MD Marquette	Daniel S. Mazzuchi, MD Marquette
Mason	Ruth V.C. Carney, MD Ludington	Christie E. Davis, MD Ludington	
Mecosta, Osceola, Lake	Leland A. Hickox, MD Big Rapids	E. W. VanAuken, MD Big Rapids	Norman V. Lincoln, MD Reed City
Menominee	John R. Heidenreich, MD Daggett	William S. Jones, Jr., MD Menominee	Fred H. Ayers, MD Daggett

Society	President	Secretary	President-elect
Midland	Daniel D. Heffernan, MD Midland	Michael S. Leahy, MD Midland	H.C. Scharnweber, MD Midland
Monroe	Anthony H. Bartolo, MD Monroe	Thomas H. Snider, MD Monroe	S. Newton Kelso, Jr., MD Monroe
Muskegon	C.A. Vandervelde, MD Muskegon	Donald P. Stratton, MD Muskegon	Norman L. Welch, MD Muskegon
Newaygo	Jess J. DeYoung, MD Fremont	Norman L. Pedelty, MD Fremont	Maynard DeKryger, MD Fremont
North Central	Vernon B. Blaha, MD Grayling	Modesto Lorenzo, MD Gaylord	Donald D. Burkley, MD Grayling
Northern Michigan	Bradford S. Foster, MD Petoskey	B. J. Kleinstiver, MD Petoskey	John E. McEnroe, MD Petoskey
Oakland	Edwin M. Knights, MD Southfield	Joel I. Hamburger, MD Southfield	Robert D. Woodward, MD Birmingham
Oceana	V. Dale Barker, MD Hart	V. Dale Barker, MD Hart	V. Dale Barker, MD Hart
Ontonagon	James P. Strong, MD Ontonagon	Karl E. Hill, MD White Pine	John Pierpont, MD White Pine
Ottawa	Melvin J. Frieswyk, MD Zeeland	Mary S. Kitchel, MD Grand Haven	M. Gary Robertson, MD Grand Haven
**Saginaw*	John E. Finger, MD Saginaw	Richard P. Heuschele, MD Saginaw	Duane B. Heilbronn, MD Saginaw
St. Clair	William T. Davison, MD Port Huron	Ronaldo S. Balboa, MD Port Huron	Armin T. Franke, MD Port Huron
St. Joseph	Mary O. Anderson, MD Leonidas	Andrejs Dimants, MD Three Rivers	Jason K. Hartjen, MD Sturgis
Sanilac	Raymond J. Winfield, MD Marlette	Gerald L. Groat, MD Sandusky	Mohan Dass Macha, MD Marlette
Shiawassee	Robert L. Roty, MD Owosso	John J. Kennedy, MD Owosso	Alfred W. Foerster, MD Owosso
Tuscola	Mitchell Urban, MD Caro	E. N. Elmendorf, II, MD Vassar	Edward J. Miles, MD Caro
Van Buren	John A. Kleber, MD South Haven	H. David Fenske, MD South Haven	Paul W. Sundin, MD Decatur
Washtenaw	Robert S. Ideson, II, MD Ann Arbor	Fred E. Patterson, MD Ann Arbor	Roger W. Postmus, MD Ann Arbor
Wayne	Ned I. Chalat, MD Detroit	Arthur A. Ulmer, MD Grosse Pointe Shores	Charles E. Darling, MD Detroit
Wexford, Missaukee	M. M. Posthuma, MD Cadillac	Charles J. Dumanois, MD Cadillac	Robert V. Daugharty, MD Cadillac

**New officers will be installed June 1.*

PEOPLE

John Reid Brown, MD, of Detroit,
has been elected to the board of trustees of Hutzel Hospital, one of the institutions in the Detroit Medical Center. Doctor Brown, a member of the Hutzel staff since 1938, served as chairman of the department of surgery for 20 years and now is honorary chairman. He also is an associate professor of surgery at the Wayne State University School of Medicine and on the surgical staffs of William Beaumont and Detroit General hospitals.

Robert R. Carpenter, MD, of Ann Arbor,
director of Primary Care and Community Medicine at the University of Michigan Medical Center, served as an adviser to the Children's Television Workshop for its new public broadcasting series on health. The series, produced for adult viewers, will be premiered during the 1974-75 television season.

James W. Copping, Jr., MD, of Port Huron,
recently served as instructor, with assistance from other physicians, of an emergency medical technician course sponsored by the St. Clair County Medical Society for 27 students.

James A. Greene, III, of Kalamazoo,
has received a $6,700 grant from the Michigan Heart Association for research into the relationship between kidney disease and high blood pressure. Doctor Greene is director of the Michigan Nephrology Center at Borgess Hospital, Kalamazoo.

Benjamin Jeffries, MD, of Harper Woods,
served as chairman of the committee on local arrangements for the 127th annual meeting of the American Psychiatric Association May 6-10 in Detroit. Among Michigan physicians invited to present scientific papers and discussions at the meeting are Bruce L. Danto, MD; Paul Lowinger, MD; Anthony J. Petrilli, MD, and Garfield Tourney, MD, all of Detroit; Gail Barton, MD; Edgar Draper, MD; Tsung-yi Lin, MD; Derek H. Miller, MD, and Ames Robey, MD, all of Ann Arbor; Elissa Benedek, MD, of Ypsilanti; Ronald M. Chen, MD, of Flint; Edward J. Lynn, MD, and Jose J. Llinas, MD, both of Lansing; Terry Stein, MD; Sumer Verma, MD, and Arnold Werner, MD, all of East Lansing; Richard A. Ruzumna, MD, of Southfield, and Ismail B. Sendi, MD, and Jacob Zvirbulis, MD, both of Pontiac.

Edgar B. Keemer, Jr., MD, of Detroit,
recently was honored by the Detroit Chapter of the National Association of Social Workers as its Public Citizen of 1974. He was cited for contributions toward the elimination of racism, sexism and poverty in America.

Henry R. Mooi, MD, of Coldwater,
has been honored by the MSMS Council in recognition of "outstanding medical service to Michigan and more specifically to the people of Coldwater and Branch County." Doctor Mooi has practiced in Coldwater since 1946 and has delivered more than 10,000 infants. He is a graduate of Hope College and the University of Michigan Medical School. The award was presented at the April meeting of the Branch County Medical Society.

Edwin L. Quinn, MD, of Birmingham,
was among scientific exhibitors at the recent 1974 Midwest Clinical Conference sponsored by the Chicago Medical Society in Chicago. His exhibit, titled "Clinical Experience with Cefazolin: A New Parenteral Cephalosporin," was based on clinical experience in studies at Henry Ford Hospital, Detroit, and the Medical College of Ohio.

Jerry C. Rosenberg, MD, of Detroit,
has been honored by the Chicago Medical School Alumni Association as one of the school's three distinguished alumni for 1973. Doctor Rosenberg is professor of surgery and director of the Robert S. Marx Surgical Research Laboratories at the Wayne State University School of Medicine.

Stephen N. Rous, MD, of East Lansing,
is the author of *Education Objectives for Undergraduate Urology*, a handbook for students, published by the Michigan State University Continuing Education Service. Doctor Rous is professor of surgery and chief of the Division of Urology at the MSU College of Human Medicine.

Raymond E. Swanson, MD, of North Muskegon,
reports on the occurrence of gonococcal ophthalmia in one stillborn and six live infants delivered in Hackley Hospital, Muskegon, in 1971 and 1972 in the April 8 issue of the *Journal of the American Medical Association*. Coauthors of the article, "Gonococcal Ophthalmia Neonatorum: Relationship of Time of Infection to Relevant Control Measures," are Theodore R. Thompson, MD, of the Michigan Department of Public Health, Lansing, and Paul J. Wiesner, MD, of the Center for Disease Control, Atlanta.

(Continued on Page 280)

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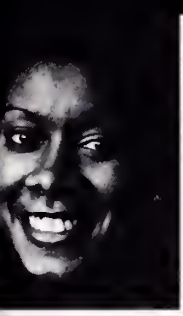
(acetaminophen)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The patient
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patient

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dehydrated child

Since there are so many, why not use TYLENOL® tablets and elixir routinely for pain or fever?

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If a rare sensitivity reaction occurs, the drug should be stopped.
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Safer than aspirin, yet just as effective for relief of pain and fever

Tylenol®
(acetaminophen)

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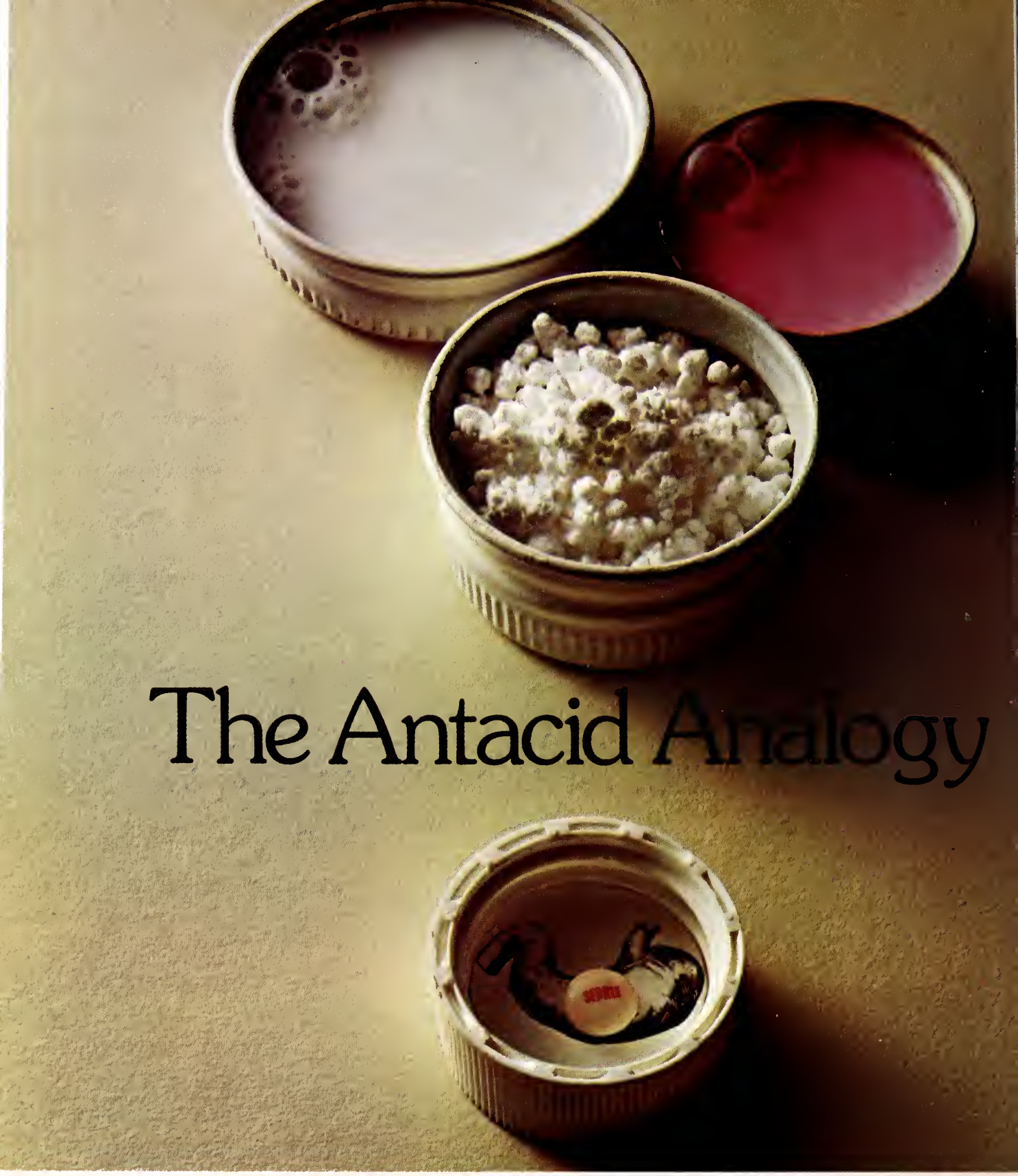

Indications: Pro-Banthine is effective as adjunctive therapy in the treatment of peptic ulcer. Dosage must be adjusted to the individual.

Contraindications: Glaucoma, obstructive disease of the gastrointestinal tract, obstructive uropathy, intestinal atony, toxic megacolon, hiatal hernia associated with reflux esophagitis, or unstable cardiovascular adjustment in acute hemorrhage.

Warnings: Patients with severe cardiac disease should be given this medication with caution.

Fever and possibly heat stroke may occur due to anhidrosis.

In theory a curare-like action may occur, with loss of voluntary muscle control. For such patients prompt and continuing artificial respiratio should be applied until the drug effect has been exhausted.

Diarrhea in an ileostomy patient may indicate obstruction, and th possibility should be considered before administering Pro-Banthine.

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Adverse Reactions: Varying degrees of drying of salivary secretions ma

Therapeutic comparisons in peptic ulcer.

Antacids have only one mode of action to relieve ulcer pain...

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propantheline bromide

Antacids:

ntacids relieve ulcer pain by neutralizing gastric cid. This action is relatively short-lived and they have o other mode of action.

Pro-Banthine:

Pro-Banthine suppresses gastric acid ecretion. The antisecretory properties of ro-Banthine are well established. By effectively locking vagotonic impulses Pro-Banthine suppresses astric secretion to reduce both total and free acid.

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Pro-Banthine reduces acidity without subsequent acid rebound. The capacity of Pro-Banthine to reduce the secretion of total and free acid in the stomach has been demonstrated in scores of studies. None has demonstrated any significant evidence of acid rebound.

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*Innes, I. R., and Nickerson, M., in Goodman, L. S., and Gilman, A. (editors): The Pharmacological Basis of Therapeutics, ed. 4, New York, The Macmillan Company, 1970, p. 537.

Pro-Banthine complements and enhances the action of antacids.

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Address medical inquiries to: G. D. Searle & Co.
Medical Department, Box 5110, Chicago, Ill. 60680

ccur as well as mydriasis and blurred vision. In addition the following dverse reactions have been reported: nervousness, drowsiness, dizziness, somnia, headache, loss of the sense of taste, nausea, vomiting, constipa-on, impotence and allergic dermatitis.

osage and Administration: The recommended daily dosage for adult ral therapy is one 15-mg. tablet with meals and two at bedtime. Subse-uent adjustment to the patient's requirements and tolerance must be ade.

ro-Banthine P.A.—Each tablet of Pro-Banthine P.A. (propantheline romide) contains 30 mg. of the drug in the form of sustained-release or timed-release beads; on ingestion about half of the drug is released within an hour and the remainder continuously as earlier increments are metabolized. Thus the result is even, high-level anticholinergic activity maintained all day and all night in most patients with only two tablets daily. Some patients may require one tablet every eight hours.

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(sodium levothyroxine)

Supplied: **Tablets:** 0.025 mg., 0.05 mg., 0.1 mg., 0.15 mg., 0.2 mg., 0.3 mg., 0.5 mg., scored and color-coded in bottles of 100, 500, and 1000.

Injection: 500 mcg. lyophilized active ingredient and 10 mg. of Mannitol, U.S.P. in 10 ml. single-dose vial, with 5 ml. vial of Sodium Chloride Injection, U.S.P., as a diluent.

Synthroid-T_4

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Deerfield, Illinois 60015

MEETINGS

May 15—106th medical alumni reunion, Wayne State University School of Medicine, Gordon H. Scott Hall, WSU Medical Campus, Detroit, contact: WSU School of Medicine, 313/577-1495.

May 16-17—Annual meeting, Michigan Chapter, American College of Emergency Physicians, at Shanty Creek Lodge, Bellaire, contact: J. Peter Johnston, MD, Henry Ford Hospital, Detroit, Mich. 48282.

May 22-23—OMERAD Symposium on Medical Education sponsored by the Office of Medical Education Research and Development, College of Human Medicine and College of Osteopathic Medicine, Michigan State University, at Kellogg Center, East Lansing, contact: Bruce Alderman, Kellogg Center, East Lansing, Mich. 48824.

May 22-24—Annual forum for hospital trustees, administrators and medical chiefs of staff, sponsored by MSMS, MAOPS and the Michigan Hospital Association, at Boyne Mountain, contact: Herbert A. Auer, MSMS Headquarters.

May 22-24—16th annual seminar on cardiopulmonary pathophysiology sponsored by the Michigan Society for Respiratory Therapy, Troy Hilton Inn, contact: MSRT, PO Box 808, Royal Oak, Mich. 48067.

May 24-25—Thirteenth Annual Kidney Disease Symposium sponsored by the Kidney Foundation of Michigan in cooperation with Henry Ford Hospital, in Buerki Auditorium, Detroit, contact Nathan W. Levin, MD, chairman, Kidney Foundation of Michigan, 3378 Washtenaw Ave., Ann Arbor, Mich. 48104.

June 4-6—Annual meeting of the Michigan Chapter of the American Academy of Pediatrics, Bay Valley Inn, Bay City, contact: Charles M. Coffman, Executive Secretary, Michigan Chapter, AAP, 4791 Haddington Dr., Bloomfield Hills, Mich. 48103.

June 8-9—Symposium in clinical neurotology, "Treatment of the Dizzy Patient," sponsored by Michigan State University College of Human Medicine at Kellogg Center, East Lansing, contact: Bruce Alderman, Kellogg Center, MSU, East Lansing, Mich. 48824.

June 12—MSMS Council, MSMS Headquarters, contact: Warren F. Tryloff.

June 19-21—Annual convention of the Michigan Hospital Association, Grand Hotel, Mackinac Island, contact: MHA office, 2213 E. Grand River Ave., Lansing, Mich. 48912.

June 22-26—AMA Annual Meeting, Chicago, contact: AMA, 535 N. Dearborn St., Chicago, Ill. 60610.

June 21-22—Meeting of Upper Peninsula Medical Society, Terrace Garden, Escanaba, contact: James R. Dehlin, MD, 8 S. 11th St., Gladstone, Mich. 49837.

July 6-10—Michigan Academy of Family Physicians Annual Meeting and Scientific Program, Park Place Motor Inn, Traverse City, contact: MAFP office, 933 Wing St., Plymouth, Mich. 48170.

July 25-26—Annual Coller-Penberthy-Thirlby Medical Conference, Park Place Motor Inn, Traverse City, contact Laurence P. Skendzel, MD, Munson Medical Center, Traverse City, Mich. 49684.

July 25-28—Summer meeting of the Michigan Psychiatric Society, Inn on the Park Hotel, Toronto, contact: Charles W. Davenport, MD, University Hospital, Ann Arbor, Mich. 48104.

Aug. 1-3—MSMS Council, St. Clair Inn, St. Clair, contact: Warren F. Tryloff.

Sept. 23-27—Family practice review, sponsored by the Michigan Academy of Family Physicians, at Scott Hall, Wayne State University School of Medicine, contact: MAFP office; 933 Wing St., Plymouth, Mich. 48170.

Sept. 25—MSMS Council, MSMS Headquarters, contact: Warren F. Tryloff.

Oct. 1—Annual surgical symposium, "Surgical Disease of the Pediatric Gastrointestinal Tract," sponsored by the Department of Surgery, Children's Hospital of Michigan, and Wayne State University School of Medicine Department of Surgery, at the hospital, contact: Department of Community Relations, Children's Hospital of Michigan, 3901 Beaubien Blvd., Detroit, Mich. 48201.

Oct. 4—Mid-year Meeting, Michigan Hospital Association, Park Place Motor Inn, Traverse City, contact: MHA office, 2213 E. Grand River Ave., Lansing, Mich. 48912.

Oct. 9-10—1974 Annual MSMS Scientific Meeting, Sheraton-Cadillac Hotel, Detroit, contact: Helen Schulte, MSMS Headquarters.

Oct. 11-12—Annual reunion of the University of Michigan Medical Center Alumni Society, Ann Arbor, contact Robert Richards, Towsley Center, Ann Arbor, Mich. 48104.

Nov. 6—MSMS Council, MSMS Headquarters, contact: Warren F. Tryloff.

Dec. 11—MSMS Council, MSMS Headquarters, contact: Warren F. Tryloff.

*Urethritis, cervicitis, proctitis when due to susceptible strains of *N. gonorrhoeae*

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Trobicin—The advantage of injectable therapy.
Once Trobicin is injected, treatment is usually complete; there can be no problems with patients sharing, skimping, skipping or forgetting medication.

Trobicin—The aspect of privacy.
There are no prescriptions to fill, no capsules to take. Neither family, friends nor co-workers need know or suspect the patient's problem.

Trobicin—Indication and dosage.
Spectinomycin is indicated only for use in acute urethritis and proctitis in the male and acute cervicitis and/or proctitis in the female when due to susceptible strains of *N. gonorrhoeae*. The usual dosage for Trobicin in adult males is 2 grams intramuscularly†; 4 grams intramuscularly in females.

Trobicin—Not effective for syphilis.
Trobicin is not effective for any stage of syphilis. Trobicin may mask or delay the symptoms of incubating syphilis. If concurrent syphilis is suspected, follow the patient serologically for at least 3 months. Patients with syphilis should receive adequate specific anti-syphilitic therapy with an appropriate antibiotic.
Trobicin is contraindicated in patients previously found hypersensitive to it.

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iminacyclitol antibiotic active *in vitro* against strains of *Neisserio gonorrhoeae* (MIC 7.5 0 mcg/ml). Definitive *in vitro* studies have vn no cross resistance of *N. gonorrhoeae* een spectinomycin and penicillin.

ications: Acute gonarrheal urethritis practitis in the male and acute ganarrheal citis and proctitis in the female when due sceptible strains of *N. gonorrhoeae*.

traindications: Contraindicated in pas previously faund hypersensitive to spectnycin.

rnings: Not indicated for the treatment af ilis. Antibiotics used ta treat gonorrhea mask or delay the symptams of incubating ilis. Patients should be carefully examined monthly serological follow-up far at least nths should be instituted if the diagnosis of syphilis is suspected.
Safety for use in infants, children ond pregnont women has not been estoblished.

Precautions: The usual precautions should be observed with atopic individuals.
Clinical effectiveness shauld be monitared ta detect evidence of development af resistance by *N. gonorrhoeae*.

Adverse reactions: The following reactians were observed during the single-dose clinical trials: soreness at the injectian site, urticaria, dizziness, nausea, chills, fever and insamnia.
During multiple-dose subchranic tolerance studies in normal human valunteers, the fallowing were nated: a decrease in hemaglobin, hematacrit and creatinine clearance; elevation af alkaline phasphatase, BUN and SGPT. In single- and multiple-dase studies in normal volunteers, a reductian in urine output was noted. Extensive renal functian studies demonstrated na consistent changes indicative af renal toxicity.

Dosage and administration: Keep at 25° C and use within 24 haurs after reconstitution with diluent.
Male—Inject 5 ml intramuscularly for a 2 gram dase. Patients with ganorrheal practitis and patients being re-treated after failure af previous antibiatic therapy should receive 4 grams (10 ml). In geographic areas where antibiatic resistance is knawn ta be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.
Female—Inject 10 ml intramuscularly for a 4 gram dase.

How supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitutian yields 5 and 10 ml respectively with a concentration of 400 mg spectinamycin per ml (as the hydrochloride). Far intramuscular use only.
Susceptibility Powder—far testing *in vitro* susceptibility af *N. ganorrhoeae*.
Cautian: Federal law prohibits dispensing without prescription.
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or patients with gonorrheal proctitis and for patients in geographic areas where antibiotic sistance is known to be prevalent, initial treatment with 4 grams is preferred.

Techniques for identifying and handling the high risk pregnancy were in the spotlight when 800 physicians, nurses and students gathered in Grand Rapids March 27 and 28 for the 1974 Michigan Conference on Maternal and Perinatal Health.

Jan Schneider, MD, obstetric service chief, University of Michigan Medical Center, moderates session on pregnancy management.

Guest speakers compare notes. From left are Richard H. Aubry, MD, perinatal director for the Upstate Medical Center, Syracuse, N.Y.; Bruce A. Work, Jr., MD, director of the obstetric intensive care unit at the U-M Medical Center, and Winnie O. Willis, RN, of the U-M School of Public Health faculty.

MSMS committee leaders Joseph L. Sheets, MD, (left) of Lansing and Richard T. Mellis, MD, of Kalamazoo, relax during conference.

Educational Conference Explores Progress in Obstetrical Care

Evidence that neonatal intensive care units can bring about significant improvements in infant mortality and morbidity was presented to 800 health professionals during the 1974 Michigan Conference on Maternal and Perinatal Health, held March 27 and 28 in Grand Rapids.

Thomas K. Oliver, Jr., MD, medical director of Children's Hospital of Pittsburgh, reported on studies indicating effectiveness of neonatal intensive care units as conferees looked closely at new ways of approaching the high risk pregnancy.

Winnie O. Willis, RN, of the University of Michigan School of Public Health faculty, told the audience of physicians, students and nurses that recent studies validate the relationship between low socio-economic status and poor pregnancy outcome.

Emphasis in the program was on the identification and evaluation of the high risk obstetrical patient and development of a management plan for her, using all the knowledge and equipment now available. Discussions covered topics ranging from the importance of the infant's nutritional environment to a new method of using ultrasonic scanning to determine gestational age of the infant.

The conference is conducted annually by the MSMS Committee on Maternal and Perinatal Health with the cooperation of several other organizations and pharmaceutical firms. The next conference will be March 26 and 27, 1975, again in Grand Rapids.

Maternal and Perinatal Health Conference Chairman Lloyd A. Kammeraad, MD (second from right), of Grand Rapids, explains his point to Thomas K. Oliver, Jr., MD (left), medical director, Children's Hospital of Pittsburgh and a guest speaker; Kenneth J. Vander Kolk, MD (second from left), of Grand Rapids, conference vice chairman, and Lee B. Stevenson, MD (right), of Farmington, chairman of the MSMS Committee on Maternal and Perinatal Health.

Blue Shield Pays After Physician Sues Patients

A Muskegon physician, Richard T. Allen, MD, was awarded two settlements March 18, by a Muskegon District Court judge, marking the doctor's success in efforts to collect his full fees charged to patients covered by Blue Shield policies.

In each case, Doctor Allen had cared for patients who had Shield coverage. The patients had refused to sign the Blue Shield Doctor's Service Report form (the pay-doctor form). Doctor Allen likewise declined to sign because he is a nonparticipating physician. Doctor Allen then billed the patients his usual fee and, after an interval of time, he sued to collect for services rendered. The cases were started in the small claims court, where cases of less than $300 can be heard by a court magistrate if both sides decide not to be represented by legal counsel.

In these cases, Michigan Blue Shield decided to provide legal counsel for the patient—in accordance with Blue Shield policy. The Shield attorney asked for detailed bills of particulars.

In one case Doctor Allen's attorney, Michael E. Kobza, of Muskegon, subpoenaed the patient as a witness. The patient testified March 18 that his labor union representative had advised him not to sign the pay-doctor form. Neither of the patients had objected to the doctor's fees and the court established that the fees were usual and customary for the services rendered.

March 18, Shield agreed to judgements of $90 and $175 in the two cases, plus court costs and $25 toward the services of Doctor Allen's attorney for each case. Shield paid a total of $357.40 in the two cases.

Commenting on the court action, Doctor Allen explained that he was "concerned with the principle involved, not the few dollars.

"At stake is the right of every doctor to set his own fees for his services without arbitrary, third-party intervention," he added.

Several other similar suits by emergency department physicians and two others by Doctor Allen have been settled in court in favor of Muskegon doctors. The first such case was in August, 1971.

Must vasodilators and therapy for other diseases come into conflict?

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The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows.

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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the cytologist's findings, it has also caused a great deal of misunderstanding and misinterpretation on the clinician's part.

Class I, III, IV and V are simple enough; it is Class II which is the source of confusion. Class II is a negative smear showing cellular abnormalities which are not considered neoplastic. Yet, all too often, it gives concern to the clinician who is not fully aware of the implications. Added to the confusion is the unfortunate fact that cytologists would not always agree among themselves on what Class II meant. Some would include cases of trichomoniasis or candidiasis or those showing more than the usual amount of purulent exudate. Eventually, the clinician would find himself with a pile of Class II reports and would be at a loss as to what to do with them.

Many cytologists have recently changed to the simplified classification of negative-doubtful-positive, by which Class I and II are negative, Class III doubtful, and Class IV and V positive. While this eliminates the unfortunate Class II confusion, it still does not prevent the less experienced cytologist from reporting a non-cancerous cell as doubtful just because it looks different from what he is used to seeing, again leading to unnecessary operations.

Carcinoma In Situ

The histological diagnosis of carcinoma in situ of the cervix has, similarly, been controversial and has been a matter of disagreement even among the experienced. The more conservative pathologist may diagnose a dysplasia of the cervix which the less conservative examiner would report as carcinoma. To the former, the difference between the two conditions may lie in the presence or absence of attempted maturation of the cells toward the surface, while such finding would be considered immaterial to the latter. Consequently, this disagreement reflects on the management of the case.

Reporting gynecological smears on special forms by placing a mark in the appropriate square is universally used and is certainly satisfactory in all negative cases. For all others the clinician should be entitled to more information than a simple hashmark. A special space should be available on the report form for the cytologist's comments. These comments should include a brief description of the suspected cells, the cytologist's opinion and doubts as to benignity or malignancy and his recommendations as to further action, such as repeat smears or diagnostic cervical conization. The information should be confined to items which are likely to aid the clinician in his assessment of the case; anything else would only confuse him and should be omitted.

Whoever screens the smear or places his final approval on the report should always keep in mind that the verdict of "positive" would entail hospitalization and a surgical procedure for the woman, to whom this would be a physical, emotional and, last but not least, financial trauma.

One should never forget the patient over a microscopic slide.

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medicine enthusiastically jump on the bandwagon of government grants to do nationwide mammography, where the yield is about 3-6 positive cases per thousand patients (2,000 exams).

Doctor Masters says "Third party payers, rising costs, rising public sophistication will no longer condone excessive orders for lab and x-ray procedures, unfair charges, or any aspect of poor medical practice." Again, without massive x-ray and lab procedures, the "computer technology" is eliminated, and everyone is liable to "poor medical practice" for not using it. Obviously, you cannot have it both ways.

Doctor Masters says we must "concentrate our energies on improving care — while at the same time reducing costs." Really now!

Lockheed bankrupt, bailed out by U.S.; Penn Central bankrupt, bailed out by U.S.; meat doubles, milk doubles, Nixon pays $700 income tax, gasoline doubles, national debt zooms, fuel oil doubles, medical dues rise, journal costs up, welfare costs skyrocket, defense costs zoom, military pay doubles, silver doubles, gold zooms, military bonus $2,500 per man, Watergate investigation costs in millions, car prices double, chemical shortage, oil profits skyrocket, legislators raise own salaries and pensions, fraud in Washington, fraud in Lansing, drug costs too high, hospital costs too high, medical costs too high, etc., etc.

And we are going to "substantially reduce medical costs?"

How are you going to lower medical costs, use new computer technology, never miss a diagnosis, but not abuse the expensive computer by ordering too many studies, make house calls in Detroit at $4 per, and so forth.

If such a world exists, where is it? Did the Bennett Amendment repeal the laws of economics?

Sincerely yours

Edward J. Dranginis, MD
Tecumseh

(Continued on Page 280)

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M GP 33

John J. Voorhees, MD, of Ann Arbor,
shared recently in the International Taub Award for Psoriasis Research administered by the Baylor University School of Medicine and Department of Dermatology. Doctor Voorhees, associate professor of dermatology at the University of Michigan, and Elizabeth A. Duell, PhD, assistant professor of dermatology, U-M, were cited for their long-term investigation on the molecular pathology of abnormal cell growth which results in psoriasis and possibly skin cancer. In 1973 Doctor Voorhees received the U-M Henry Russel Award recognizing scholarly achievement and service to the university.

O.R. (Ray) Yoder, MD, of Ypsilanti,
was honored in March as the Ypsilanti Rotary Club's first Rotarian of the Month. Doctor Yoder retired in 1964 after 22 years as superintendent of the Ypsilanti State Hospital. He was cited by the Rotary Club for his contributions to medicine in Michigan and his participation in other civic activities.

Physician Asks Reports of Insect Bite Reactions

Dear Scientific Editor:

Again, this year I am compiling case reports of allergic reactions to biting insects, i.e., mosquitoes, fleas, gnats, kissing bugs, bedbugs, chiggers, black flies, horseflies, sandflies, deerflies, etc. I am also interested in reactions to the Imported and Southern Fire Ants.

I would like physicians to supply me with case reports of those patients who have had reactions to such insects. Include in your reports the type of reaction and complications, if any, and the age, sex and race of the patient, the site of the bite(s), the season of the year, the immediate symptoms, the skin test results, desensitization results, if any, and any associated other allergies. Please send this information to me at the address shown below.

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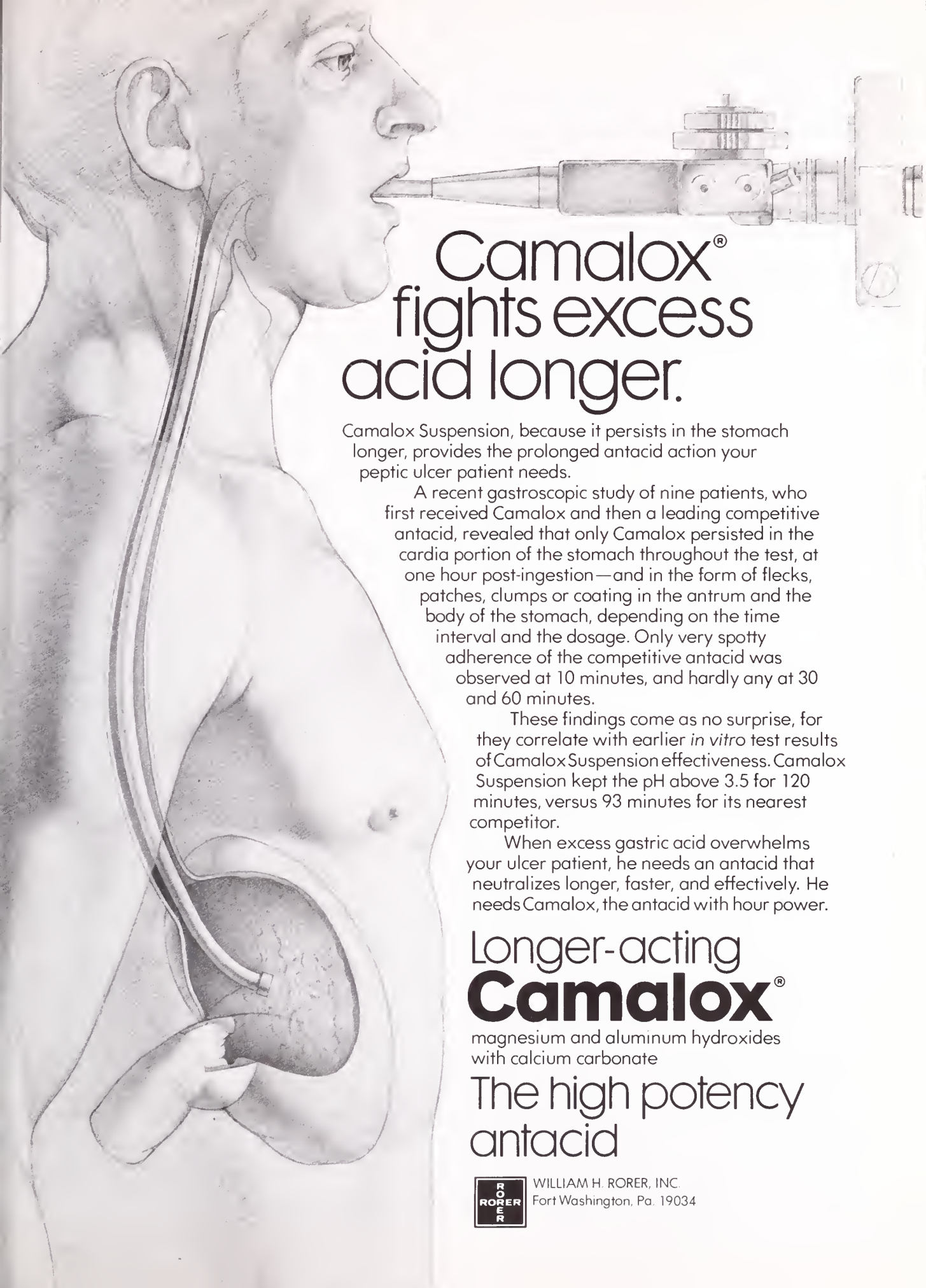

Camalox® fights excess acid longer.

Camalox Suspension, because it persists in the stomach longer, provides the prolonged antacid action your peptic ulcer patient needs.

A recent gastroscopic study of nine patients, who first received Camalox and then a leading competitive antacid, revealed that only Camalox persisted in the cardia portion of the stomach throughout the test, at one hour post-ingestion—and in the form of flecks, patches, clumps or coating in the antrum and the body of the stomach, depending on the time interval and the dosage. Only very spotty adherence of the competitive antacid was observed at 10 minutes, and hardly any at 30 and 60 minutes.

These findings come as no surprise, for they correlate with earlier *in vitro* test results of Camalox Suspension effectiveness. Camalox Suspension kept the pH above 3.5 for 120 minutes, versus 93 minutes for its nearest competitor.

When excess gastric acid overwhelms your ulcer patient, he needs an antacid that neutralizes longer, faster, and effectively. He needs Camalox, the antacid with hour power.

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The high potency antacid

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Socio-Economic

AMA Statistics Provide New Data on Physicians Practicing in Michigan

By John Anthony, Chief, MSMS Bureau of Economic Information

More than 54 per cent of the U.S. medical graduates practicing in Michigan attended medical schools in the state. Of the total, 8.3 per cent trained in Illinois and make up the second largest group. Canadian medical graduates practicing here total more than 400, or 3.4 per cent of the total.

There were 12,293 MDs, including interns and residents, in Michigan as of June, 1973. Foreign medical graduates numbered 3,122 or 25.4 per cent of the total. Almost 64 per cent of the foreign medical graduates completed school within the last 12 years, compared with a third of the Michigan graduates who entered practice during the same period.

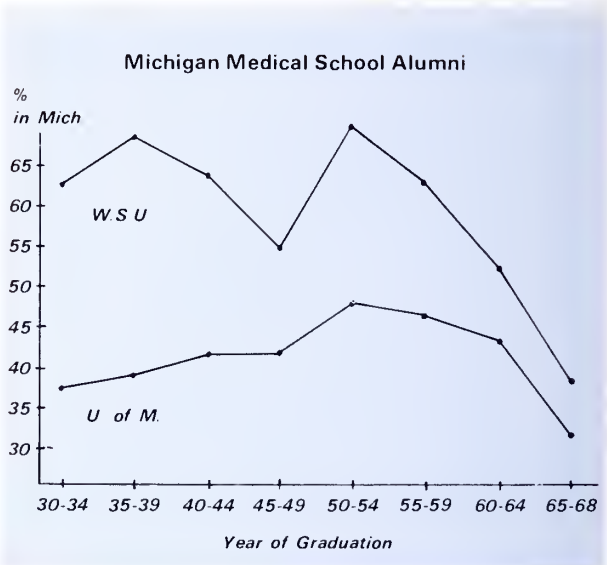
These are a few examples of the type of information being generated by the MSMS Bureau of Economic Information. The bureau recently acquired a master physician information data file from the AMA Center for Health Services Research and Development. The tables, charts and graphs were prepared from resources now available to MSMS.

The Medical School Graduation Report gives the year and place of graduation of physicians in Michigan.

The graph entitled Michigan Medical School Alumni shows the per cent of Michigan graduates still in Michigan by the year of graduation. The year 1968 was used as the last year to compare information because physicians who were graduated after that date may still be in residency programs.

The Michigan physician population increased 24.9 per cent from 1964 to 1972, compared with a 26 per cent increase in the nation as a whole during the same period.

The chart entitled Medical Specialists in Michigan shows a substantial switch from family practice to specialization between 1964 and 1972. The largest percentage increase among specialties was in internal medicine.



In 1972, Michigan had 2,453 interns and residents for 21.6 per cent of the total MD population; in 1964, interns and residents totaled 1,947, or 20.6 per cent of the total.

In 1972, 722 physicians, or 6.2 per cent of the total, were in medical education administration or research, an increase of 237 from the 485, or 5.1 per cent of the total, in the same activities in 1964.

Future issues of *Michigan Medicine* will offer more demographic information about Michigan physicians. The bureau will identify the place of internship and residency training of Michigan physicians. These analyses are being conducted to determine physician mobility and to aid to the efforts of MSMS committees working on keeping Michigan graduates here and bringing more physicians to Michigan.

School or Locale of Education of MDs in Michigan by Year of Graduation

Michigan Medical Schools Grads Report

Year	U of M	WSU	MSU	Total Mich Grads	Non Mich US Grads	Canada Grads	FM Grads	Total
1923 and earlier	101	81		182	133	38	21	374
1924	17	9		26	26	8		60
1925	29	6		35	24	2		61
1926	20	20		40	35	13	1	89
1927	24	9		33	29	2	5	69
1928	29	12		41	32	2	2	77
1929	43	23		66	29	4	3	102
1930	38	21		59	31	4	1	95
1931	46	21		67	29	3	3	102
1932	44	32		76	38	3	4	121
1933	37	29		66	45	3	3	117
1934	35	35		70	39	2	5	116
1935	31	41		72	60		6	138
1936	45	40		85	64	8	9	166
1937	27	46		73	63	3	7	146
1938	31	48		79	58	5	10	152
1939	41	41		82	77	4	13	176
1940	53	34		87	84	6	12	189
1941	46	35		81	95	2	11	189
1942	40	32		72	76	4	14	166
1943	87	112		199	118	7	21	345
1944	39	47		86	76	4	24	190
1945	61	34		95	90	3	12	200
1946	56	31		87	106	3	15	211
1947		30		30	102	3	26	161
1948	55	33		88	106	4	34	232
1949	37	22		59	126	3	46	234
1950	39	37		76	82	12	52	222
1951	55	44		99	103	10	57	269
1952	66	42		108	106	15	72	301
1953	75	37		112	114	16	82	324
1954	68	41		109	112	16	74	311
1955	79	44		123	98	19	89	329
1956	86	40		126	99	14	102	341
1957	94	42		136	80	13	96	325
1958	73	45		118	93	24	105	340
1959	97	39		136	81	13	89	319
1960	86	36		122	76	24	128	350
1961	87	41		128	68	10	126	332
1962	73	64		137	81	12	174	404
1963	66	60		126	79	10	177	392
1964	67	51		118	89	7	183	397
1965	49	46		95	78	8	202	383
1966	65	34		99	86	8	188	381
1967	60	30		90	99	11	203	403
1968	60	46		106	103	14	202	425
1969	74	55		129	105	3	163	400
1970	55	54		109	110	4	158	381
1971	86	54		140	119	4	83	346
1972	80	77	15	172	145	14	9	340
Total	2,752	1,983	15	4,750	3,997	424	3,122	12,293

(Continued on Page 286)

Welcome

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

Roshan Ara, MD, 1579 W. Big Beaver Rd., Troy 48084
Peter D. Atchoo, MD, 562 Tanview Dr., Oxford 48051
J. Jay Baker, MD, 2745 Albert Dr., S.E., Grand Rapids 49506
Josephine N. Balatan, MD, 37737 Wixford Pl., Westland 48185
Carl G. Benner, MD, 999 Sixth St., Traverse City 49684
Robert P. Blau, MD, 20001 Greenfield, Detroit 48235
Jon H. Blum, MD, 29657 Fairfax, Southfield 48076
Michael T. Bodley, MD, 2509 Hall St., S.E., Grand Rapids 49506
Nicholas C. Bosch, MD, 3061 Burton St., S.E., Grand Rapids 49506
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Parish B. Cleveland, MD, Box 115, Grosse Ile 48138
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John W. Cowden, MD, 540 E. Canfield, Detroit 48201
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Lewis L. DeKryger, MD, 1011 Fulton St., E., Grand Rapids 49503
John S. Dunn, MD, 1200 Michigan Ave., East Lansing 48823
Lamberto E. Eugenio, MD, 3079 Shattuck Arms Blvd., Saginaw 48603
Riad Farah, MD, 2799 W. Grand Blvd., Detroit 48202
Mahmood Fassihi, MD, St. Mary's Hosp., Livonia 48154
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MSMS to Help Sponsor Hospital Forum

"Health Care Controls and Quality — a Paradox?" will be the theme of the eighth annual Medical Staff-Trustee-Administrator Forum planned by the Michigan Hospital Association for May 22, 23 and 24 at Boyne Mountain Lodge, Boyne Falls. MSMS is a cosponsor of the forum, which will be concerned with legal aspects of controlled patient care and PSROs.

Keynote speaker will be Gerald Seifert, director of the Health Law Center, Aspen Systems Corp., Rockville, Md. MSMS President Brooker L. Masters, MD, will take part in the program, along with C. Allen Payne, MD, president, Michigan Medical Practice Board; Donald C. Smith, MD, director of the Michigan Office of Medical Affairs, and Julien Priver, MD, executive vice president, Sinai Hospital of Detroit. Lewis E. Simoni, MD, of Flint, is chairman of the planning committee for the forum.

Interested physicians may contact Herbert A. Auer at MSMS Headquarters.

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Medical Specialists in Michigan

	As of 12/31/64 % of Total	As of 12/31/72 % of Total
General and Family Practice	24.9	15.6
Medical Specialties		
Allergy	.5	.6
Cardiovascular Diseases	.6	1.4
Dermatology	1.4	1.3
Internal Medicine	13.0	15.2
Pediatrics	5.3	6.1
Pulmonary Diseases	.5	.5
Surgical Specialties		
General Surgery	11.1	11.4
Neurological Surgery	.6	.8
Obstetrics & Gynecology	7.6	7.8
Ophthalmology	3.2	3.2
Orthopedic Surgery	2.2	2.8
Otolaryngology	1.7	1.6
Plastic Surgery	.4	.6
Colon & Rectal Surgery	.3	.3
Thoracic Surgery	.7	.8
Urology	1.6	1.9
Other Specialties		
Anesthesiology	2.3	3.1
Neurology	1.4	.8
Occupational Medicine	.6	1.3
Psychiatry	9.5	7.9
Pathology	3.5	3.5
Physical Medicine & Rehabilitation	.1	.4
Public Health	.4	.7
Radiology	3.3	4.6
All others	3.3	5.8
Total	100.0	100.0

Michigan Physicians Medical Graduation Location

STATE	NUMBER OF GRADS
Michigan	4,751
Illinois	728
Pennsylvania	350
Ohio	343
New York	338
Wisconsin	208
District of Columbia	198
Missouri	191
Tennessee	191
Massachusetts	176
Indiana	172
Iowa	131
California	127
Maryland	117
Minnesota	109
Nebraska	104
Virginia	61
Kansas	48
Connecticut	45
Kentucky	45
Texas	45
North Carolina	44
Colorado	37
Louisiana	34
Oklahoma	31
Puerto Rico	18
Vermont	18
Arkansas	15
Oregon	14
Georgia	12
Washington	12
South Carolina	9
Florida	6
Utah	5
West Virginia	5
New Jersey	4
Alabama	3
Mississippi	1
New Mexico	1
Total U.S. Grads	8,747
Total Canada Grads	424
Total Foreign Medical Grads	3,122
Final Totals	12,293

(as of June, 1973)

Spasm reactor?

Donnatal®!

	each tablet, capsule or 5 cc. teaspoonful of elixir (23% alcohol)	each Donnatal No. 2	each Extentab
hyoscyamine sulfate	0.1037 mg.	0.1037 mg.	0.3111 mg.
atropine sulfate	0.0194 mg.	0.0194 mg.	0.0582 mg.
hyoscine hydrobromide	0.0065 mg.	0.0065 mg.	0.0195 mg.
phenobarbital (warning: may be habit forming)	(¼ gr.) 16.2 mg.	(½ gr.) 32.4 mg.	(¾ gr.) 48.6 mg.

Brief summary. Adverse Reactions: Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Contraindications: Glaucoma; renal or hepatic disease; obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); or hypersensitivity to any of the ingredients.

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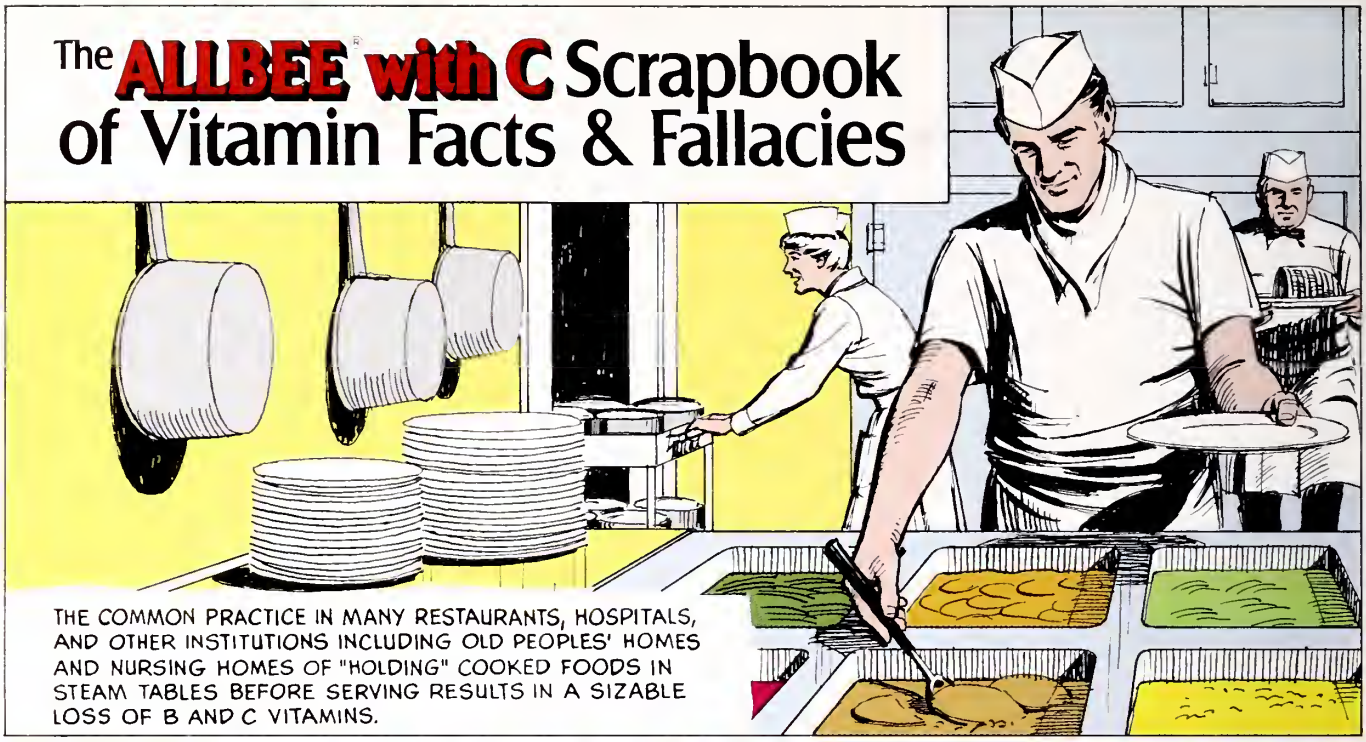
The ALLBEE® with C Scrapbook of Vitamin Facts & Fallacies



THE COMMON PRACTICE IN MANY RESTAURANTS, HOSPITALS, AND OTHER INSTITUTIONS INCLUDING OLD PEOPLES' HOMES AND NURSING HOMES OF "HOLDING" COOKED FOODS IN STEAM TABLES BEFORE SERVING RESULTS IN A SIZABLE LOSS OF B AND C VITAMINS.

DURING THE CIVIL WAR 30,714 CASES OF SCURVY WERE REPORTED, AND 383 DEATHS WERE ATTRIBUTED DIRECTLY TO THE DISEASE.

THE AMOUNT OF SUNLIGHT AVAILABLE DURING RIPENING DETERMINES TO A LARGE EXTENT THE FINAL ASCORBIC ACID CONTENT OF TOMATOES. HENCE, A COOL, WET SUMMER PRODUCES WATERY, LESS TASTY FRUIT THAT'S LOWER IN VITAMIN C.

RONSSENS, A DUTCH PHYSICIAN, WROTE IN 1564 THAT "DUTCH SAILORS WHO, RETURNING FROM SPAIN, WERE ATTRACTED BY THE NOVEL RICHNESS OF THE FRUIT (ORANGES) AND BY THEIR GREED AND GLUTTONY, UNEXPECTEDLY DROVE OUT THE DISEASE (SCURVY), AND HAD THIS HAPPY EXPERIENCE NOT ON A SINGLE OCCASION ONLY, BUT REPEATEDLY."

Available on your prescription or recommendation

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Integument!

Our skin—the human integument—covers us, defines us, protects us. But skin is subject to cuts, burns, abrasions. And infections. Neosporin Ointment fights infection by providing broad antibacterial action against susceptible skin invaders. It contains antibiotics that are rarely used systemically, reducing the risk of sensitization.

INDICATIONS: *Therapeutically*, used as an adjunct to appropriate systemic therapy for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

PRECAUTION: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Complete literature available on request from Professional Services Dept. PML.

NEOSPORIN® Ointment

(POLYMYXIN B-BACITRACIN-NEOMYCIN)

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg. (equivalent to 3.5 mg. neomycin base); special white petrolatum q.s. In tubes of 1 oz. and ½ oz. and 1/32 oz. (approx.) foil packets.

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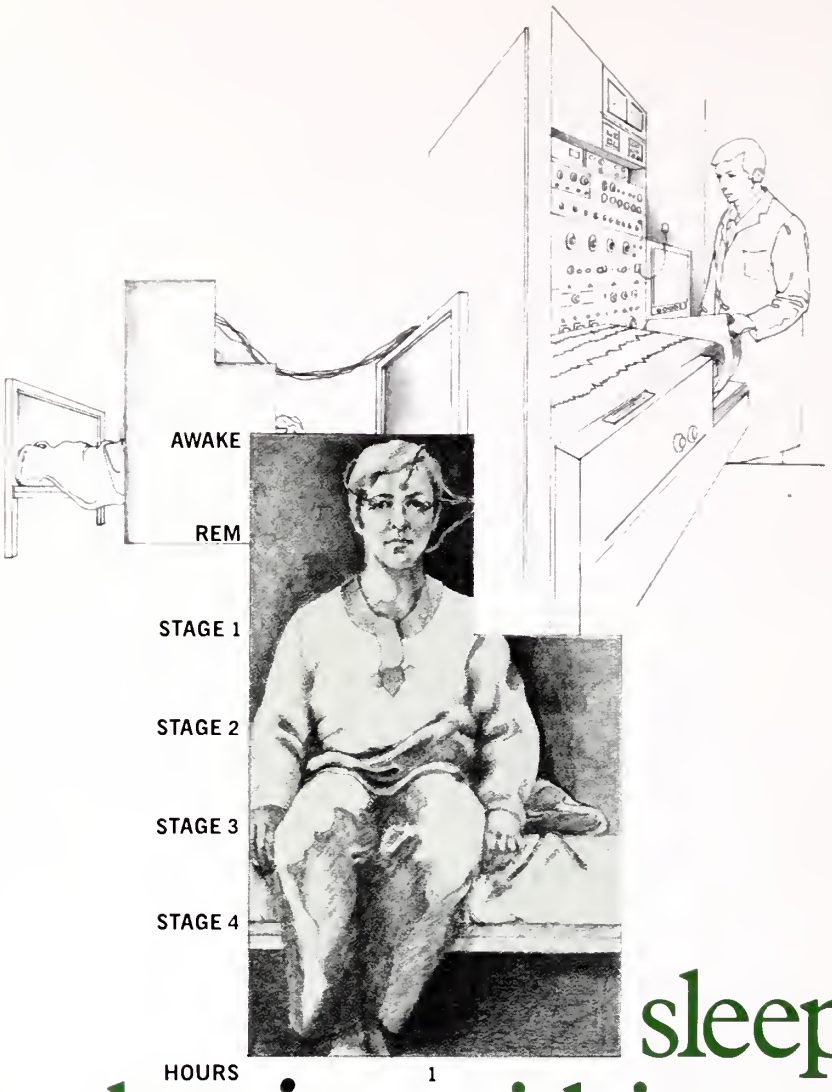
North Carolina 27709



sleep begins within 17 minutes, on average...

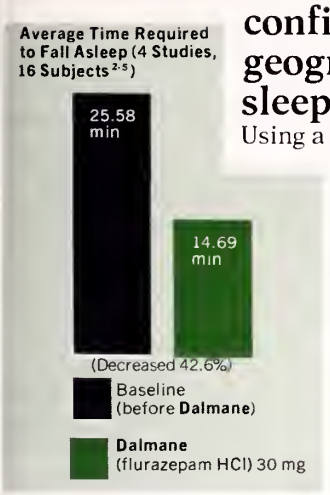
an initial benefit of

Dalmane®

(flurazepam HCl)

proved by a 22-night clinical study of insomnia patients in the sleep research laboratory and at home[1]

Three insomnia patients selected for difficulty falling asleep were administered Dalmane (flurazepam HCl) 30 mg for 14 consecutive nights. Placebo was given for four nights prior to and four nights after Dalmane. Physiologic tracings on Dalmane nights 1-3 showed sleep induction time averaged 13.90 minutes; on Dalmane nights 12-14, 18.80 minutes. Combined average for the 6 monitored drug nights was 16.35 minutes.[1]


Average Time Required to Fall Asleep (4 Studies, 16 Subjects [2-5])
25.58 min
14.69 min
(Decreased 42.6%)
Baseline (before Dalmane)
Dalmane (flurazepam HCl) 30 mg

confirmed by clinical studies in four geographically separated sleep research laboratories [2-5]

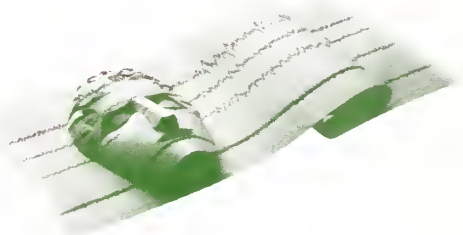
Using a 14-night protocol involving eight insomniac and eight normal subjects, four studies confirmed the sleep-inducing effectiveness of Dalmane (flurazepam HCl) and the reproducibility of this response. On average, one 30-mg capsule induced sleep within 17 minutes. In all these studies, Dalmane induced sleep rapidly, reduced nighttime awakenings, and provided 7 to 8 hours of sleep without repeating dosage[2-5]

Dalmane (flurazepam HCl) induces and maintains sleep, with relative safety

Dalmane is generally well tolerated; morning "hang-over" has been relatively infrequent. While dizziness, drowsiness, lightheadedness and the like have been noted most often, particularly in the elderly and debilitated, physicians should be aware of the possibility of more serious reactions, as noted below.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.
Contraindications: Known hypersensitivity to flurazepam HCl.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.
Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.
Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.
Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.
Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



when restful sleep is indicated

Dalmane®
(flurazepam HCl)

One 30-mg capsule *h.s.* — usual adult dosage
(15 mg may suffice in some patients).
One 15-mg capsule *h.s.* — initial dosage for elderly or debilitated patients.

- **induces sleep within 17 minutes, on average**
- **reduces nighttime awakenings**
- **sustains sleep 7 to 8 hours, on average, without repeating dosage**

REFERENCES: 1. Kales A, *et al*: *Arch Gen Psychiatry 23*:226-232, Sep 1970
2. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971
3. Frost JD Jr: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
4. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
5. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ

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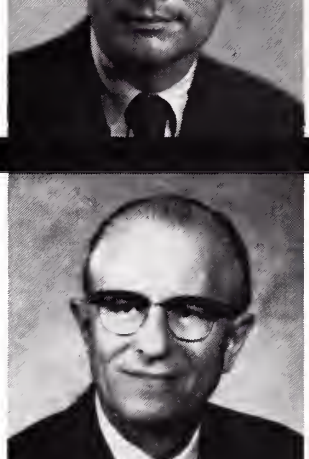
Opinion & Dialogue

Is there a need for a drug compendium?

Government Health Official

Henry E. Simmons, M.D.
Deputy Assistant Secretary for Health Department of Health, Education and Welfare



A drug compendium of the type I envision would fill a definite need for the practicing physician. Such a compendium would give him all the information necessary for using a drug intelligently, and it would do so in a clear, concise, convenient, objective and balanced fashion.

What a Compendium Should Contain

I believe the compendium should inform the doctor what a drug will do, when he should use it for what type of patient, for how long, in what dose, what benefits his patient is likely to obtain, the risks involved, and cross-reactions with other drugs.

The information would be based on the package insert and have the same legal status. In fact, a complete compendium with complete and current information might even eliminate the necessity

Maker of Medicine

Joseph F. Sadusk, Jr., M.D.
Warner-Lambert Company

A drug compendium, or preferably compendia, should, I believe, be private, not federal, in sponsorship. They should contain comprehensive listings of drugs available for prescribing. They should be single, legibly printed volumes of reasonable size, updated quarterly or semiannually and completely revised every year

Function of a Compendium

A compendium should furnish the following information on drugs in the following order: indications for use, side effects, adverse drug reactions, contraindications, drug interactions, drug dosage and the dosage forms marketed. Drug prices should not be included because they vary so widely and change rapidly.

No compendium should set forth drugs of choice or discuss relative efficacy. Such questions must be left for the practicing physician to decide, whether on the basis of the medical literature, his own clinical experience, advice of colleagues, information supplied by manufacturers, and so on.

Nor should a compendium undertake to educate the doctor on how to use drugs. Rather, it must be a reference source designed primarily to refresh his memory as to drugs he may not use regularly. It

for a package insert in many instances. This would constitute a substantial saving for the manufacturer.

By a complete compendium, I do not mean a volume of prohibitive size. You don't need a book describing 25,000 products with an enormous amount of repetition. Rather, drugs should be arranged by class. Mutually applicable information would be provided, along with brief discussions pinpointing differences in specific drugs of that class. Listings would be cross-indexed in a useful way.

Other Available Documents as Sources of Information

Existing references such as PDR and the AMA Drug Evaluation are obviously useful but they are incomplete. Either they are not cross-referenced by generic name and do not group drugs with similar characteristics, or they do not list all the available and legally marketed drugs. And some of those omitted may be very useful. On the other hand, drugs made by more than one supplier, tetracycline for example, may be fully described a dozen times in the same book.

While perhaps PDR could be rearranged and cross-indexed with generics included, and while the AMA Drug Evaluation might also be modified and expanded, I am not sure that the end result would have all the attributes required for a useful compendium. At the same time, you would run the risk of amassing a voluminous and unwieldy tome.

Should Editorial Comments Accompany the Listings?

Subjective judgments, in my opinion, have no place in a compendium. However, if there is substantial evidence based on a sound body of science concerning relative efficacy of several drugs, certainly that information should be included. The committee of experts compiling and editing a particular section would also have to assess and indicate instances where a meaningful difference between drugs is pertinent.

Sponsorship, Compilation and Editing

Producing a book like this would undoubtedly be difficult and demanding. It would obviously take a great deal of talent and expertise, and would require a varied and experienced group, ranging from writers and editors to highly skilled clinicians and pharmacologists. Style, format and clarity of language would play an important part in determining the usefulness of the book. And it should be updated periodically and completely revised annually.

I have no opinion whether the government or the private sector should sponsor and/or finance the compendium. What is most important is that the compendium be an authoritative, objective and useful source of information for the doctor to have at hand as a ready reference.

---

should in no way imply control over the practitioner's prerogatives.

Why Another Compendium?

A practicable, single-volume compendium cannot, nor is it necessary to, include all drugs on the market today. From my practice of internal medicine for some 15 years, my experience as a consultant, and as a faculty member of four or five medical schools, I would estimate that a doctor uses only 30 to 35 drugs regularly. The 1972 Physicians' Desk Reference, incidentally, contained about 2,500 entries.

As to whether there should be a federal compendium, in my opinion, as stated earlier, the answer is easy—there should *not* be one. The proposal assumes that existing compendia are inadequate. We're not sure of that at all. Whatever its imperfections, the present drug information system in the U.S. is open, multifaceted, pluralistic and extensive. Good compendia exist, as well as other ample sources on drug therapy, ranging from journal literature through AMA Drug Evaluation to company materials. Not all physicians may use such sources as often or as well as they should, but that is the fault of the man, not of the sources.

In any event, rather than produce another book, it makes much more sense to work on improving existing compendia, and perhaps they could, as knowledge advances, include more accumulated clinical data and experience, and more information on drug interactions and adverse reactions.

Implications of a Federal Compendium

Take a hard look at the implications of a federal compendium. It would have the force of law, virtually dictating what drugs to use and how to use them. In effect, it would be a regulatory document with legal or quasi-legal status, posing medical/legal problems similar to those the doctor may now encounter if and when he departs from the provisions of the package insert. A compendium under federal aegis would tend to restrict decisions on drug therapy to one orthodox level—a most dangerous trend for medicine.

New Compendium—A Medical Option

I detect no ground swell of initiative or support whatsoever for a federal compendium—or, for that matter, for a new compendium of any type. A 1969 PMA survey conducted by Opinion Research Corporation found that only 15 per cent of those physicians interviewed felt a new compendium was needed. And a large majority did not favor the involvement of the federal government if one were to be created, preferring instead a nongovernmental consortium.

Even if we come to a time when the medical profession itself opts for a new kind of compendium, it should be handled and financed, ideally, outside both government and industry. Final review and editorial authority could be delegated, say, to specialty bodies and medical societies—but above all, *not* the government.

Surely the health care system in the United States has far more vital matters to consider than the extensive cost and effort that would have to go into the preparation and maintenance of a new, monolithic compendium, and especially one bearing the imprimatur of the federal government.

Opinion & Dialogue

What is your opinion, doctor? We would welcome your comments.

The Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

P·M·A

Education

Most WSU Medical Graduates Will Intern in Michigan

Sixty-eight per cent of Wayne State University's 1974 medical graduates will remain in Michigan to begin postgraduate educational programs, the university has announced.

Of the 168 graduates, 115 have accepted internships in Michigan, according to Marilyn Heins, MD, associate dean for student affairs at the WSU School of Medicine.

This represents a small improvement from 1973 when 82 of the 121 graduates, or 67 per cent, remained in Michigan, but a larger change from 1972, when 60 per cent stayed in Michigan, and 1971, when only 42.5 per cent remained in the state.

"We are pleased that an increasing number of WSU School of Medicine graduates are remaining in Michigan for their internships," said Robert D. Coye, MD, dean. "We have made special efforts to interest our graduates in a medical career in Michigan."

U.P. Medical Training to Begin in Fall

The Michigan State University College of Human Medicine will begin an innovative program to train physicians in the Upper Peninsula this fall. Ten students who are from the U.P. or have other special ties with the area have been chosen for the initial class, according to Ronald W. Richards, PhD, director of the Office of Medical Education Research and Development for the medical school.

Students will study basic sciences at universities in the Upper Peninsula and complete clinical work in a model family practice setting. They will be able to complete most of their medical education in the U.P. The program is designed to produce more family physicians interested in practicing in the Upper Peninsula. One of the physicians assisting with planning is Raymond L. Hockstad, MD, of Escanaba, a member of the MSMS Council.

U-M Lists Schedule of Courses in PG Medical Education

Following is a listing of courses in postgraduate medical education to be offered this year by the Department of Postgraduate Medicine and Health Professions Education of the University of Michigan. All of the courses will be at the U-M Medical Center, Ann Arbor, unless otherwise noted.

May 17	*Basic Burn Care*
May 21-24	*Advances in Internal Medicine*
June 3-5	*Advances in Clinical Neuroscience*
June 6-7	*Blood Banking*
June 13 & 14	*Pulmonary Disease Workshop*
June 24-28	*Northern Michigan Summer Course, Bellaire*
Sept. 24-26	*Blood Coagulation Techniques*
Oct. 2	*Social Work Conference*
Oct. 3	*Continuing Pathology Conference*
Oct. 8-10	*Cardiology for Internists*
Nov. 7	*Continuing Pathology Conference*
Nov. 8 & 9	*Advanced Burn Care*
Nov. 15 & 16	*Anesthesiology Conference*
Dec. 4	*Cardiology for Family Physicians*
Dec. 6	*Basic Burn Care*

Inquiries should be directed to Robert K. Richards, Director, Office of Intramural Education, Department of Postgraduate Medicine, Towsley Center, Ann Arbor, Mich. 48194.

Mercy College Tells Plans for New Degree

Mercy College of Detroit has announced that it will begin offering a bachelor of science degree in health sciences in the fall, 1974, school term. Specifically designed for persons who are employed in health care but do not have baccalaureate degrees, the program initially will admit graduates of accredited two-year college or community college programs and certified, registered or licensed as health professionals.

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In Memoriam

Don A. Cohoe, MD
Troy

Don A. Cohoe, MD, 86, an otolaryngologist practicing in Highland Park for more than 50 years, died April 13 in Beaumont Hospital. Doctor Cohoe was on the staff of Highland Park General Hospital and was a former member of the Wayne County Medical Society Council.

A graduate of the Wayne State University School of Medicine, he served as a medical corps officer in World War I.

Lester C. Kraft, MD
Leslie

Lester C. Kraft, MD, of Leslie, died April 10 at the age of 72. Doctor Kraft, a family physician, was on the staff of Foote Hospital in Jackson, but had been in semi-retirement in recent years. He was a graduate of the Detroit College of Medicine.

James J. Lentine, MD
Detroit

James J. Lentine, MD, 62, a family physician in Detroit and a lifelong Detroit resident, died April 8. He was a staff member at Bon Secours and St. John hospitals and an honorary staff member of South Macomb and Detroit Memorial hospitals. Doctor Lentine was graduated from the Wayne State University School of Medicine.

William P. Martzowka, MD
Saginaw

William P. Martzowka, MD, 74, of Saginaw, died March 15 in St. Luke's Hospital in Saginaw. A 1924 graduate of the University of Michigan Medical School, Doctor Martzowka practiced in Saginaw until his retirement in 1969. He was a past president of the Saginaw Academy of Family Physicians.

Ernest L. Stefani, MD
Detroit

Ernest L. Stefani, MD, of Detroit, former chief of staff at Mt. Carmel Mercy Hospital, died April 7 at the age of 76. Doctor Stefani, who specialized in general and abdominal surgery, was a former Detroit Department of Health commissioner. He received his medical education at St. Louis University.

Medico-Legal

The AMA's Citation *newsletter, prepared by the AMA Law Department, lists the following cases involving health personnel in Michigan. Persons interested in obtaining more information on individual cases may write MSMS headquarters.*

"Mental patient cannot consent to innovative psychosurgery"
Wayne County Circuit Court, Mich, July 10, 1973
from *The Citation*, Vol. 28, No. 2

"Vasectomy suit barred by statute of limitations"
Michigan Court of Appeals, April 26, 1973
from *The Citation*, Vol. 28, No. 2

"Dismissal of malpractice action against physician reversed"
Michigan Court of Appeals, May 22, 1973
from *The Citation*, Vol. 28, No. 2

"Regulation of sale and advertising of abortion-inducing drugs upheld"
Michigan Supreme Court, June 18, 1973
from *The Citation*, Vol. 28, No. 2

"Attorneys' failure to bring medical malpractice suit"
Michigan Court of Appeals, April 26, 1974
from *The Citation*, Vol. 28, No. 2

"Abortion conviction of nonphysician upheld"
Michigan Supreme Court, June 18, 1973
from *The Citation*, Vol. 28, No. 3

"Claim that malpractice suit was based on revenge improper"
Michigan Court of Appeals, July 23, 1973
from *The Citation*, Vol. 28, No. 6

"Nurse's aide sues doctor for attack by patient"
Michigan Court of Appeals, July 25, 1973
from *The Citation*, Vol. 28, No. 7

"Last treatment or discovery rule applicable in Malpractice Suit"
Michigan Supreme Court, Dec. 21, 1973
from *The Citation*, Vol. 28, No. 12

"New trial granted after judge enters jury room"
Michigan Court of Appeals, Nov. 1, 1973, rehearing denied Dec. 7, 1973
from *The Citation*, Vol. 28, No. 12

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ENT, Urology, Chief of E.R., and Fam Pract; Southern Maine; near Portland; 90 mi. Boston; 55,000 immediate service area, 115,000 in York County; great potential; delightful living; write Physician Search and Reception Committee, T. Anton, M.D., (Chairman); c/o Administrator, Webber Hospital Assn.; Biddeford, ME 04005

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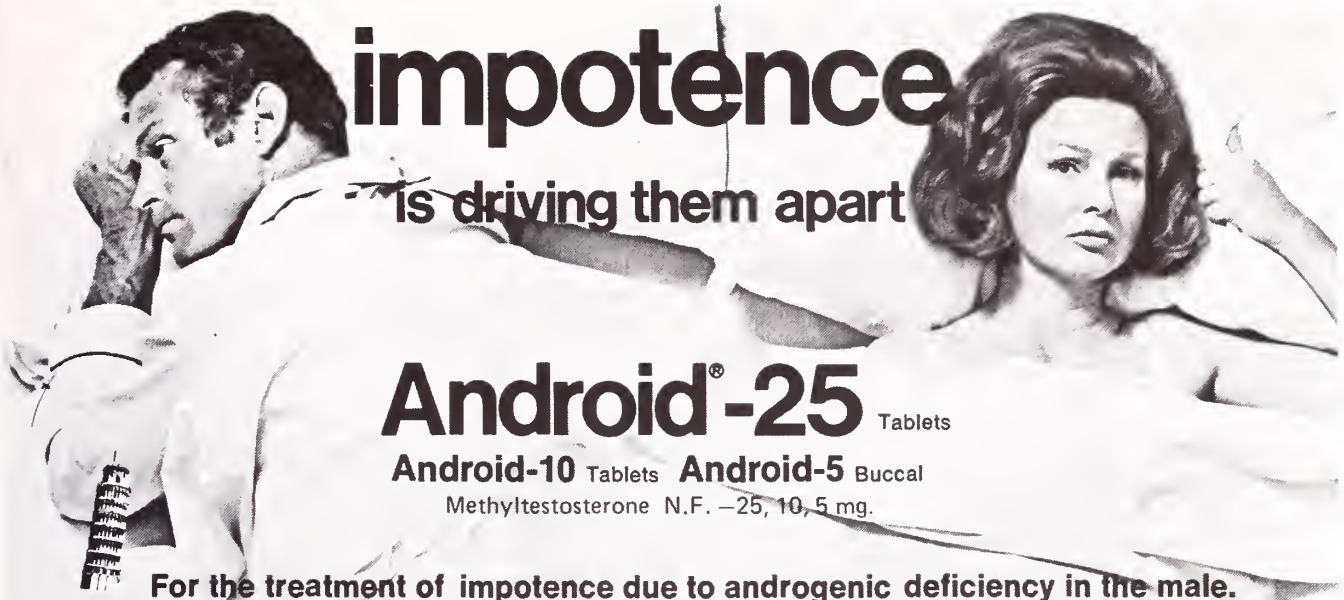

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Beating the Deadline

By Herbert A. Auer, Executive Editor

Who says doctors don't make house calls? The *Muskegon Chronicle* had a warm, human interest feature story recently about **Constantine L. A. Oden, MD,** who makes house calls on a 90-year-old patient who is confined to a wheel chair. "I help keep her strong," explained Doctor Oden. Doctor Oden is 81 years young.

Thousands of fliers entitled "So You Have a Foot Problem — The Bunion Story" are being distributed by the American Orthopaedic Foot Society to doctors for distribution to patients. The readable, attractive folder was written by **William H. Blodgett, MD,** Detroit, chairman of the AOFS Committee on Public Relations.

Cecelia F. Hissong, MD, Dearborn, will be installed as the first woman president of the Michigan Academy of Family Physicians, at the MAFP annual meeting at Traverse City in July. She will succeed Louis R. Zako, MD, Dearborn Heights.

Thomas Bass, MD, Ann Arbor, recently received the Distinguished Service Award from Alpha Phi Alpha, Theta Zeta Lambda chapter, for his contribution to the community.

A call has been issued by **Ronald L. Krome, MD,** Detroit, for original papers that physicians want to deliver at the American College of Emergency Physicians Scientific Assembly Nov. 4-6 in Washington, D.C. Doctor Krome is chairman of the ACEP Section on Education.

William T. Sallee, MD, Detroit ophthalmologist appeared recently on the Michigan Association of the Professions "Special — Report" program over WJIM-TV in Lansing. The theme was "To See or Not to See."

Seldom does MSMS receive a letter from some other state about a Michigan doctor, but one arrived recently which stated in part, "We congratulate Michigan on having such an outstanding physician as **Doctor Sidney Chapin** of Dearborn." The letter from the Lexington, Ky., Health Department praised Doctor Chapin specifically for his help there at a University of Kentucky Medical Center lecture to promote home care program.

Michigan Medicine . . .April, 1956

Dirk Gringhuis, who created all the covers for *Michigan Medicine* for six years, 1955-1960, died in April in East Lansing, where he was a member of the MSU faculty. Memorial contributions to the American Cancer Society were suggested by the family. Among his MSMS journal covers were a number that dealt with the challenge of slaying the cancer dragon. Dirk was nationally known as an author and illustrator of historical stories for children.

Dr. Oden

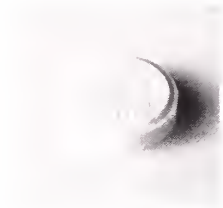
Dr. Sallee

Dr. Blodgett

Dr. Hissong

This page will appear each month with news items "on the human side" gathered from correspondence, meetings, conversations and tips we hope you will send in from time to time.

respond to one



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For further information on this subject, the following references are provided:

1. Henry BW, *et al: Dis Nerv Syst 30*:675-679, Oct 1969.
2. Hollister LE, *et al: Arch Gen Psychiatry 24*:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970.

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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The cover photograph of the Chicago skyline calls attention to the AMA Convention opening there June 22 and is courtesy of the Chicago Convention and Tourism Bureau, Inc. See Page 324 for a report on Michigan participation in the event.

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Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. In editorials, the views expressed are those of the writer and not necessarily official positions of the society.

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President's Page

Delegates Should Tell MSMS Story to Physicians and Public

MSMS President Brooker L. Masters, MD, called on MSMS delegates to "tell our MSMS story to the physicians and to the public" as he addressed the 1974 Annual Session May 5 at the Boyne Mountain Lodge. Following are excerpts from his address.

"The need for unity in the medical profession is of paramount importance. Each of us at this meeting of the House of Delegates must find new ways to strengthen our unity further. Apathy, inertia and indifference continue as roadblocks that must be pushed aside.

MSMS President Masters addresses delegates.

"We face two immediate jobs.

"First, we need to talk with our fellow physicians and to listen to their views so we can adopt wise policy positions and work to accomplish our goals.

"Second, as physicians, we need to increase our personal activities to explain to the public the special concerns doctors have as we dedicate ourselves to quality medical care.

"Please help tell our story to the public. I am convinced that one of the solutions to our problems is for more one-to-one communication. There is no substitute for a personal appearance by a doctor — you — before the lawyers, pharmacists or hospital workers in your community; or before the ministers, teachers and the social workers, or before the League of Women Voters, the Jaycees or the labor unions.

"Let me add some positive ways that you can do just that:

"Get a copy from MSMS of a prepared speech about medical costs and give the talk to your noonday luncheon club.

"Write MSMS for a copy of the prepared talk about chiropractic. Go give that address to the parents of emotionally-disturbed children.

"Get some notes from MSMS about some of the legislative bills pending in Lansing. Then talk about HMOs, for example, to the local Farm Bureau or the insurance agents.

"MSMS can provide help so you can tell groups in your town about the effective efforts of MSMS to enlarge the medical schools, to place 100 medical students in community hospitals for the summer, etc.

"These are four quick, specific suggestions about speeches each of you could make soon — and often — to groups in your town."

"We have a golden opportunity to tell the people that medical care is very, very good in Michigan."

Letters

New Programs Will Aid the 'Sick Physician'

To MSMS Members:

In November, 1972, the American Medical Association House of Delegates adopted a report on "Physicians with Psychiatric Disorders Including Alcoholism and Drug Dependence." The delegates felt a need for some practical approach to aid physicians burdened with these problems.

In the past, proper solutions were delayed because the treatment of choice was punishment rather than rehabilitation. The doctor would lose his hospital appointment, if he had one; he would be expelled from his medical society, if he belonged or he would have to surrender his license if he had broken a law or had been found guilty of immoral or unprofessional conduct. In most states this is still the prevailing procedure, but because it is punishment it is seldom prevailed upon.

In Michigan, the new Medical Practice Act, signed into law several months ago, has a "sick physician" provision which will provide the legal structure to handle the problem. Once identified, the sick physician can be referred to the Medical Practice Board. If indicated, his license can be temporarily suspended until there is a proper resolution of the problem. The difficulties in early detection and in developing proper referral channels for appropriate treatment remain.

Recommendations were outlined in the American Medical Association report and implementation was left to the individual state and county medical societies. In turn, the Michigan State Medical Society Council asked its Committee on Alcohol and Drug Dependency to develop a proposal for implementation. That committee developed a "proposal for rehabilitation of mentally ill and/or drug addicted (including alcoholic) physicians." Its feeling was that the State Medical Society can and should act as a compassionate agency for coordinating efforts to detect, treat, and rehabilitate many of these unfortunate colleagues before they harm patients, break laws, lose hospital and practice privileges and bring discredit on the profession.

Other groups have experience in this area. The San Francisco Medical Society has activated an advisory committee to serve physicians who have emotional problems. A group in Oregon, Friends of Medicine, has evolved outside the structure of organized medicine for a similar purpose. Locally the Wayne County Medical Society for many years has had a "Counsellor Service" to handle physicians' problems secondary to illness. Referrals are made through the various committees, individuals or the physician himself. Industry has a growing interest in this area since early detection and proper treatment, if possible, has obvious benefits for everyone concerned. "Insight — a Program for Troubled People" for employees and dependents of the Kennecott Copper Corp. is one example of an industrial program which has demonstrated positive results. A key note of all groups is confidentiality and a program of rehabilitation.

The Michigan State Medical Society Council has authorized the appointment of a Committee on Rehabilitation of Sick Physicians which is charged with the responsibility of developing a final protocol for appropriate action. The charge is challenging. As such, it would be helpful to hear comments from the membership on how you perceive the problem of the "sick physician." Of particular interest would be comments relating to programs you have knowledge of or have worked with that have demonstrated positive results in this area of concern.

Sincerely,

H. Richard Henderson, MD, Detroit
Chairman, MSMS Committee on Rehabilitation of Sick Physicians

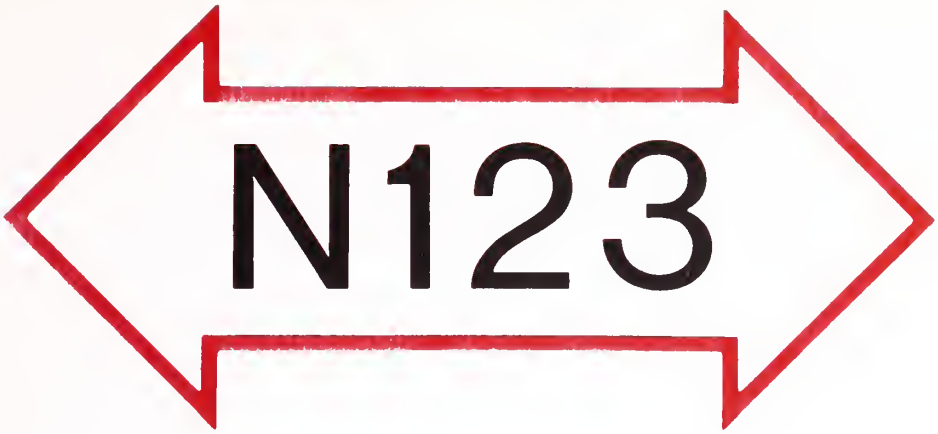
Reprinted from *Detroit Medical News*

Physicians Invited to Mushroom Conference

To the Editor:

I would greatly appreciate your publishing a notice about the Aspen Mushroom Conference designed for physicians, scientists and amateur mycologists interested in the identification and toxic properties of mushrooms. The conference is sponsored by the Beth Israel Hospital, Denver, and the Colorado Mountain College, Glenwood Springs, Colo., and will be held Aug. 26-30 at the Inns of Court, Snowmass-at-Aspen, Colo. For information, contact Aspen Mushroom Conference, Beth Israel Hospital.

Sincerely,
Emanuel Salzman, MD
Chief, Division of Radiology
Beth Israel Hospital
1601 Lowell Blvd.
Denver, Colo. 80204



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Rep. Guy Vander Jagt (left) and MDPAC Chairman Louis R. Zako, MD, chat during MDPAC dinner.

Mark C. Levine, MD, of Flint (left), greets Rep. Richard VanderVeen after delegates hear from lawmakers.

Annual Session Report

Establishment of a new MSMS membership category for physicians-in-training, approval of activities designed to improve relationships with third party payors and expansion of the society's staff for intensified liaison with government were among measures approved by the House of Delegates at its 1974 Annual Session in May at Boyne Mountain Lodge.

A summary of House action was sent to all members in the May 10 issue of *Medigram* and a more detailed report is available from the MSMS Department of Communication. Official proceedings will be published later in *Michigan Medicine.*

In a guest address before the House, Carl Smith, Jr., president of the State Bar of Michigan, told delegates that lawyers and physicians must look to the common ground they share as professionals in seeking solutions to professional liability problems. "Our prime duty is to serve people, with our training, with our expertise, with our native ability, you in one aspect of their needs, and we in another," said Smith.

Other guest speakers during the session were Raymond T. Holden, MD, of Washington, D.C., a member of the AMA board of trustees, and U.S. Representatives Richard VanderVeen (D-Grand Rapids) and Guy Vander Jagt (R-Cadillac). The congressmen addressed delegates at a dinner arranged by the Michigan Doctors Political Action Committee (MDPAC).

State Bar of Michigan President Carl Smith, Jr., tells delegates of lawyers' concerns.

Richard T. Allen, MD, of Muskegon Heights (left), shares a table and MDPAC dinner conversation with Dr. and Mrs. Robert E. Paxton, of Fremont.

MSMS 1974 Awards of Commendation honor premier achievements of (from left) Doctors Stroup, Payne and Doty.

Doctors Doty, Payne, Stroup Get Commendation Awards

James R. Doty, MD, of Lapeer; C. Allen Payne, MD, of Grand Rapids, and Clayton K. Stroup, MD, of Flint, were paid the Michigan State Medical Society's highest tribute when they were awarded Certificates of Commendation at the 1974 Annual Session at Boyne Mountain Lodge in May.

Doctor Doty, chief of ophthalmology and otolaryngology at Lapeer County General Hospital for 20 years, is a past president of the Lapeer County Medical Society, the Michigan Triological Society and the Saginaw Valley Academy of Ophthalmology and Otolaryngology. He was cited as one of the first Michigan doctors to support the concept of a combined hospital staff.

Doctor Payne, a pathologist who served as MSMS president in 1966-67, has been a member of the Michigan Medical Practice Board (formerly the Board of Registration in Medicine) since 1963 and president since 1969. Since 1938 he has been director of laboratories at Blodgett Memorial Hospital in Grand Rapids. He also serves on the governor's Advisory Commission on Physicians' Assistants and as director of the new Grand Valley Blood Program.

Doctor Stroup, who has practiced in Flint for 46 years and was the first physician in his area to practice gastric endoscopy, has won international recognition for his contributions to the establishment of professional alcoholism programs. He has served as president of the Genesee County Medical Society and the Michigan Society of Internal Medicine. Doctor Stroup is director of the alcoholism therapy program at Hurley Hospital, Flint.

Richard J. McMurray, MD, of Flint, served as chairman of the Committee on Certificates of Commendation.

Herbert A. Auer (right), MSMS manager of communication and professional information, receives award for 15 years of service, from Robert M. Leitch, MD, MSMS Council chairman.

MSMS Councilor Marion G. McCall, Jr., MD, of Detroit, devotes close attention to House proceedings.

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Lateral Cesarean Section

By J. C. Rhee, MD; Jose Peralta, MD; F.G. Mariona, MD, FACOG, and A.A. Hodari, MD, FACOG, FACS, Detroit

The supine hypotension syndrome originally described by Hansen in 1942,[4] is a rather unique sequence of events that may result ultimately in depression of the fetus. According to numerous reports, compression of the maternal vena cava by the pregnant uterus initiates maternal hypotension which, in turn, decreases uterine and placental perfusion. The resultant restriction of gaseous exchange across the placenta may engender moderate to severe degrees of fetal anoxia. Although it is apparent that a somewhat indirect causal relationship exists between maternal hypotension and fetal anoxia, Holmes, more than a decade ago, perceived the supine hypotension syndrome as a primary cause of mortality in healthy young patients delivered by Cesarean section.[6]

Ueland et al[11] have pointed out that maternal cardiovascular dynamics may be profoundly influenced by posture. In unanesthetized patients it was determined, for example, that rotation from the supine to the left lateral position resulted in a 44 per cent increase in stroke volume, a 34 per cent increase in cardiac output and a five per cent decrease in pulse rate. Noting further that under spinal anesthesia, the supine position evoked an immediate decrease in blood pressure, stroke volume and cardiac output, they were led to conclude that hypotension is the chief consort of spinal anesthesia in the supine position. Significantly, however, they suggested that this condition may be completely reversed by turning the patient to the left side.

The following investigation was therefore undertaken to evaluate the theoretic contention that the lateral position represents a more desirable approach to delivery by Cesarean section. The important aspects of maternal cardiovascular dynamics and the major physiological parameters of fetal stability were evaluated on the basis of position alone, and, secondly, in terms of position in relation to the type of anesthesia.

From the Department of Obstetrics and Gynecology, Detroit Memorial Hospital and Crittenton Hospital, Detroit.

Figure 1: Patient positioned for lateral Cesarean section

Materials and Methods

A total of 39 Cesarean sections were performed in pregnant patients at term. Seventeen were performed in the supine position. Of the remaining 22 cases, seven were performed in left lateral position and 15 were performed in left tilt position. The left lateral position was achieved by turning the patient to her left side on the surgical table and positioning the abdomen so that it barely overhung the edge of the table *(Figure 1)*. The obstetrician was seated on a low stool throughout the procedure with his shoulder at the level of the linea nigra. The uterus was exposed by a transverse abdominal incision and the infant was delivered manually. As as result of numerous and varied objections to this position *(the details of which will be discussed in the following)*, the tilt position was subsequently adopted. This position was achieved by tilting the patient and/or the table from 10 to 15 degrees, thereby enabling the surgeon to stand during the procedure.

(Continued)

Scientific Articles

TABLE 1

INDICATIONS FOR CESAREAN SECTION

POSITION	REPEAT	CPD	TOXEMIA	PRM	FETAL DISTRESS
Lateral	9 (40.9%)	8 (36.3%)	0(0%)	3 (13.5%)	2 (9.1%)
Supine	5 (29.5%)	5 (29.5%)	2 (11.7%)	2 (11.7%)	3 (17.6%)

TABLE II

DISTRIBUTION OF MATERNAL PARAMETERS ACCORDING TO POSITION

POSITION	PULSE Pre-An./ Post-An.	BLOOD PRESSURE Pre-An.	BLOOD PRESSURE Post-An.	BLOOD PRESSURE Post-Deli.	TIME ANES.→ DELIVERY	LENGTH OF SURGERY	Hgb Pre-Op.	Hgb Post-Op.
Supine	97/96	123/78	117/77	122/74	14 min.	64 min.	12.2	10.5
Lateral	90/98	106/64	100/59	126/70	15 min.	65 min.	11.3	11.1
Tilt	92/93	117/77	125/71	118/69	15 min.	65 min.	12	10.2

The time elapsed from commencement of anesthesia until delivery and the length of surgery were recorded. Maternal blood pressure and pulse rate were monitored prior to, during, and after the administration of anesthesia, and pre- and postoperative hemoglobin levels were determined. Upon delivery of the infant, 20 cc of blood were obtained in a heparinized syringe by venipuncture of the umbilical vein after the cord had been double-clamped. From this sample, fetal pH, pCO_2, pO_2, actual bicarbonate, oxygen saturation and total oxygen content were assayed immediately. The weight and Apgar score of the newborn were also recorded.

Results

Table I summarizes the indications for Cesarean section according to the position in which the procedure was performed. The generally similar distribution of cases in each position was considered significant in terms of establishing a comparative basis for evaluation of the results.

It was immediately apparent that maternal pulse rate, hemoglobin, and blood pressure, the duration of anesthesia and the length of surgery were not significantly different in supine, lateral or tilt position *(Table II)*. The mean distribution of fetal parameters *(Table III)* immediately suggested that with the exception of pCO_2, which was 15 per cent higher in the lateral position, no important variation in fetal status had occurred. However, to ensure that the results of this investigation be given maximum credibility, it was considered desirable to ascertain a number of similar parameters of fetal stability following spontaneous vaginal delivery. Average values for Apgar score, pH, pCO_2, and pO_2 in 10 infants delivered spontaneously per vagina are therefore presented in Table IV.

TABLE III

DISTRIBUTION OF PARAMETERS OF FETAL STABILITY ACCORDING TO POSITION

POSITION	1 MIN. APCAR	BABY WEIGHT (g)	pH	pCO_2	pO_2	SO_2	ACTUAL BICARB.	TOTAL CO_2 CONT.
Supine	8	2765	7.32	42.7	28.0	53	22	23
Lateral	8	3041	7.30	48.9	27.5	53	21.5	22.6

In evaluating the effect of anesthesia upon the mother *(Table V)*, it was apparent that a decrease in blood pressure in the supine position resulted only under general anesthesia. Inasmuch as the decrease was only ten per cent, little importance was attached to this observation. It also was evident that in the lateral position anesthesia was without effect upon blood pressure.

Comparison of the type of anesthesia relative to position *(Table VI)* revealed the absence of major changes in blood pressure that were not directly referable to the anesthetic method in either the supine or the lateral position. The only apparent variations were the previously noted 10 per cent in systolic pressure in supine position under general anesthesia and a 10 per cent decrease in diastolic

TABLE IV

FETAL APGAR, pH, AND BLOOD GAS ANALYSIS FOLLOWING SPONTANEOUS VAGINAL DELIVERY

	APGAR	pH	pCO_2	pO_2
	9	7.30	41.1	42.8
	7	7.34	46.2	49.6
	9	7.42	36.5	30.5
	8	7.33	42	40
	9	7.32	41.5	28.3
	9	7.33	45.5	32.2
	7	7.34	44	28.4
	8	7.24	45.6	21.9
	6	7.26	51	10
	8	7.41	45.1	20.8
MEAN	8	7.33	43.9	30.45

pressure in the lateral position under general anesthesia. It may be of some significance that under spinal anesthesia, not even slight fluctuation of blood pressure was evident.

Evaluation of the effect of anesthesia upon the fetus *(Table VII)* indicated that in the supine position pCO_2 and total CO_2 content were slightly decreased under spinal anesthesia. However, the most significant alteration was a 25 per cent decrease in oxygen saturation under spinal anesthesia. In the lateral position under spinal anesthesia, a slight decrease in pH, and minor elevations in pCO_2 and pO_2 were observed. It was of interest that in the lateral position the mean Apgar score was more than a point higher under spinal anesthesia.

(Continued)

TABLE V

EFFECT OF POSITION AND TYPE OF ANESTHESIA UPON MATERNAL BLOOD PRESSURE AND FETAL APGAR

SUPINE			
ANESTHESIA	BLOOD PRESSURE Pre-Anes.	BLOOD PRESSURE Post-Anes.	APGAR
Spinal	111/69	110/66	8
General	132/85	120/74	7.5

LATERAL			
ANESTHESIA	BLOOD PRESSURE Pre-Anes.	BLOOD PRESSURE Post-Anes.	APGAR
Spinal	108/67	109/64	8.2
General	123/84	121/72	7

TABLE VI

THE COMPARATIVE EFFECT OF SPINAL AND GENERAL ANESTHESIA UPON THE MOTHER

ANESTHESIA/ POSITION	BLOOD PRESSURE Pre-Anes.	BLOOD PRESSURE Post-Anes.
Spinal Supine	111/69	110/66
Spinal Lateral	108/67	109/64
General Supine	132/85	120/74
General Lateral	123/84	121/72

TABLE VII

EFFECT OF POSITION AND TYPE OF ANESTHESIA UPON FETAL pH, BLOOD GASES, AND APGAR SCORE

SUPINE							
ANESTHESIA	APGAR	pH	pCO_2	pO_2	SO_2	ACTUAL BICARB.	TOTAL CO_2 CONT.
Spinal	8	7.33	40	29	46	21	22
General	7.5	7.31	43.6	29	57	22	27

LATERAL							
ANESTHESIA	APGAR	pH	pCO_2	pO_2	SO_2	ACTUAL BICARB.	TOTAL CO_2 CONT.
Spinal	8.2	7.28	53	29	55	21	23
General	7	7.33	44	24	52	23	24

TABLE VIII

THE COMPARATIVE EFFECTS OF SPINAL AND GENERAL ANESTHESIA UPON THE FETUS

SPINAL							
POSITION	APGAR	pH	pCO_2	pO_2	SO_2	ACTUAL BICARB.	TOTAL CO_2 CONT.
Supine	8	7.33	40	30	46	21	22
Lateral	8	7.28	53	29	55	21	23

GENERAL							
POSITION	APGAR	pH	pCO_2	pO_2	SO_2	ACTUAL BICARB.	TOTAL CO_2 CONT.
Supine	7.5	7.31	44	29	57	22	27.5
Lateral	7	7.33	44	24	52	23	24

Comparison of anesthesia relative to position *(Table VIII)* indicated that spinal anesthesia in the lateral position resulted in slightly lower pH levels, a greater degree of oxygen saturation and higher levels of pCO_2. Under general anesthesia, pH remained unchanged and oxygen saturation was observed to be higher in the supine than in the lateral position. We may perhaps attach some significance to the fact that blood gas analysis indicated with great clarity that position sustains no apparent effect upon fetal pH and blood gases *(Table IX)*. In response to the suggestion that complications of the pregnancy may have influenced the results, we subsequently compared fetal pH and blood gas studies in cases in which repeat Cesarean section was the sole indication for the procedure. In this way, it was assumed that any possible interference directly attributable to fetal distress had been eliminated. This comparison suggested unequivocally that fetal outcome was unaffected by the position in which Cesarean section was performed *(Table X)*.

Comment

Ansari et al[1] and Waldron and Wood have postulated that a 10 degree downward tilt of the left side and/or complete lateral position may significantly improve the oxygenation of infants delivered by Cesarean section, owing to the alleviation of caval compression in the mother which results in an increase in cardiac output and greater uterine perfusion. Radiographic studies of parturients in the supine position[4] have demonstrated complete or partial obstruction of the inferior vena cava to the passage of contrast media, although subsequent postpartum evaluation confirmed the normal patency of the vessel. Kerr[7] has reported that cardiac output may be increased by 25 per cent in the left lateral position. Ueland et al[11] have shown that the change from supine to lateral position following subarachnoid block anesthesia caused cardiac output to increase by as much as 2600 cc per minute and stroke volume to more than double.Colon-Morales[3] has recommended the use

TABLE IX

COMPARISON OF FETAL pH AND BLOOD GASES ACCORDING TO POSITION

POSITION	pH	pCO_2	pO_2	SO_2	HCO_3^-	TOTAL CO_2
Lateral	7.31	49.5	26.8	54	22.4	23.5
Tilt	7.30	48.5	27.7	52.7	20.25	21.25
Supine	7.32	42.7	28.0	53	22	23

TABLE X

FETAL pH AND BLOOD GASES IN CASES OF REPEAT CESAREAN SECTION

POSITION	pH	pCO_2	pO_2	SO_2	HCO_3^-	TOTAL CO_2
Lateral	7.32	46.4	27	54	21.6	22.4
Supine	7.30	46	30	49	23	24

of a plunger-like device to achieve left lateral displacement of the uterus and thereby alleviate caval compression. Others have recommended the prophylactic use of ephedrine, a peripheral vasoconstrictor, to augment venous back flow to the heart, upon the theory that circulatory changes are responsible for poor oxygenation of the placenta and therefore the infants delivered by Cesarean section.[9]

It is interesting and perhaps significant that nowhere in the literature published by investigators in the United States has Cesarean section in the lateral position been evaluated. This implies a certain rigidity in adherence to established methods, a suspicion that was confirmed by the numerous and varied objections we encountered in attempting such an evaluation in our hospital. The initial objection was voiced by the anesthesiologist who was reluctant to administer spinal anesthesia to patients in lateral position on the grounds that this position opposes even distribution of the anesthetic. As an alternative, it was suggested that spinal anesthesia be given either in the sitting position or with the patient lying on her side, that the patient then be placed in supine position until the anesthetic had been evenly distributed, and that she then be positioned for lateral Cesarean section. A second objection was raised because of the difficulty in intubating the patient in lateral position should such complications as severe hypotension, cardiac failure, emesis, respiratory paralysis or depression, convulsions, anesthetic failure or total spinal arise during the procedure. Another consideration was the excursion of the recumbent lung in the lateral position.

Considerable opposition to Cesarean section in the lateral position under general anesthesia was voiced as well. The point was argued on the grounds that intubation could be performed only in supine position, following which, the patient would have to be repositioned for surgery. Inasmuch as repositioning alone consumed anywhere from five to 10 minutes in addition to the time needed for prepping and draping the patient, it was assumed that the resultant prolongation of anesthesia *(a primary cause of fetal depression and hypoxia)* would thus negate any possible advantage gained from the lateral position. It is of interest that only one anesthesiologist was willing to intubate in the lateral position. Thus, the first battleground that had to be conquered was the anesthesia department, with responses ranging from the reluctant perhaps to an absolute refusal.

Seven Cesarean sections were done in the lateral position. Evaluation of the results at this point, in compliance with the anesthesia department's request, failed to demonstrate any meaningful changes in maternal and fetal parameters; thus, the tilt position was adopted as a compromise measure. Comparison of position and type of anesthesia revealed no significant changes in pulse or blood pressure in either position following spinal or general anesthesia. The average duration of anesthesia and length of surgery were essentially the same in both positions. Similarly, the fairly constant relationship of blood loss to changes in hemoglobin during surgery indicated that this factor as well was unaffected by the change in position. As other investigators have noted, the lateral position did elicit a change in pulse rate. Inasmuch as the decrease was a mere five per cent, no particular importance was attached to this finding. Although it was immediately apparent that these results were contradictory to previous reports, our observations have caused us to speculate whether the lateral position in fact offers a viable solution to the hypotension syndrome. Hypotension has been definitively established as a 30 per cent decrease in blood pressure. In view of the evidence that in both the supine and lateral positions the decrease in blood pressure was only 6 mm Hg in the systolic and in the tilt position only 6 mm Hg in the diastolic pressure, we were forced to conclude that by no conceivable exercise of the imagination could any of these differences be interpreted as indicative of hypotension. The apparent absence of hypotension may be related to the fact that the patients were well-hydrated and that the type of anesthesia was prudently selected and efficiently administered.

The second battleground was that of convincing the surgeon to alter his method of performing Cesarean sections. Inasmuch as Cesarean section is one of the most basic surgical procedures, most obstetricians are fairly committed to a certain technique. A number of unfamiliar situations were encountered with the patient in lateral position, such as the change from standing to sitting position, the necessity of working sideways and levorotation of the uterus which places the right uterine vessels in the surgical field. Furthermore, the shower of amniotic fluid and the discomfort of the assistant who had to bend over combined to make a most unhappy surgical team. Despite the fact that such problems are not uncommon to the inception of any new surgical procedure, the extreme degree of discomfort to everyone was a prominent factor in our election of the tilt position.

Ansari et al[1] have reported a 42 per cent increase in the oxygen saturation of blood from the umbilical vein and a 79 per cent increase in the oxygen saturation of blood from the umbilical artery in infants delivered by Cesarean section in the tilt position under spinal anesthesia. Differences in the same direction, though of lesser magnitude, were demonstrated when general anesthesia was given. Haselhorst and Stromberger[4] and others[2, 10] have reported that oxygen saturation is lower in infants delivered by Cesarean section under spinal anesthesia than in those delivered spontaneously.

(Continued)

Our findings have not confirmed this, inasmuch as mean values for pH, pCO_2, pO_2 and Apgar score under spinal anesthesia in either lateral or supine position were essentially the same as the means established from the evaluation of fetal blood gases following spontaneous vaginal delivery.

Consideration of Apgar score relative only to position revealed that the Apgar was unaffected by the change from supine to lateral position. However, when the type of anesthesia was taken into account, we observed higher Apgar scores in infants delivered in both positions under spinal anesthesia. Notably, in the lateral position the observed difference was one point.

We were also unable to confirm the notion that fetal oxygenation is improved in the lateral position since only a one per cent variation was noted when we compared oxygen saturation levels in the supine, lateral and tilt positions. Of the remaining fetal blood gas parameters, pH, pO_2, actual bicarbonate and total CO_2 were nearly identical in all positions. Although a 16 per cent increase in pCO_2 in the lateral position was noted, this difference was presumed to be unimportant in view of the equivalence of other parameters and the lack of effect upon oxygen saturation.

Inasmuch as the evaluation of fetal blood gases relative to positioning alone failed to confirm the preferability of Cesarean section in the lateral position, we then attempted to interpret our findings relative to both position and the type of anesthesia. Interestingly enough, comparison of the anesthetic in the lateral position revealed that fetal oxygen saturation was slightly higher with spinal anesthesia than with general anesthesia. Under general anesthesia, the most obvious difference was a 10 per cent higher oxygen saturation level in the supine position than in the lateral position. Previous reports describing the relationship between oxygen saturation and Apgar score have indicated that an oxygen saturation level below 40 per cent signals impending fetal distress, but that at this level the distress may be transient and without demonstrable effect upon Apgar score. However, below 30 per cent Apgar scores may be affected. In this investigation, there was no evidence of less than 30 per cent oxygen saturation.

Further definition of lateral position as complete lateral or tilt revealed an absence of differences in any of the fetal blood gases. Accordingly, this finding justified our position that the data from tilt and lateral Cesarean sections could be combined without introducing interpretative error. The comparison of Cesarean section in lateral and supine position performed in cases where previous Cesarean section was the sole indication for the procedure was undertaken to preclude any possible interference from maternal or fetal complications that might influence the results. Although this comparison did reveal a slightly lower degree of oxygen saturation in the supine position, the fact that the decrease was without statistical significance and that the other parameters were unaffected led us to speculate that positioning may not be as critical to fetal stability as previous reports would lead us to believe.

From the evidence at hand, it is apparent that the emphasis on lateral Cesarean section as a means of preventing supine hypotension may be misplaced. Our results suggest instead that the anesthetic technique may be more closely related to changes in maternal blood pressure that subsequently precipitate untoward sequelae in the fetus. Although our findings have led us to regard with some skepticism the contention that maternal hypotension may be alleviated and fetal stability concomitantly improved with lateral Cesarean section, we have nonetheless concluded that further evaluation of the lateral technique represents the only rational approach to the resolution of this question.

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Attempted Suicide and the Emergency Room Doctor

By Bruce L. Danto, MD, Detroit

Hospital emergency room personnel and physicians are thrown into contact with many difficult types of problems. Among the most difficult to diagnose, treat and arrange disposition for is the suicidal person. Assuming that survival is possible, the suicidal patient can be helped in terms of his medical emergency by suturing a self-inflicted laceration or by placing him in I.C.U. if he has brain stem depression or is comatose from a drug overdose. Many times, simple watching and medical supportive measures are all that medical treatment requires. Doctors and emergency room personnel know how to do this work very well and the attempted suicide today has a good chance of recovery from the threatened mortality and possible morbidity of his behavior.

However, what the doctor and his emergency room team do not seem to know about is what to do psychiatrically for the patient. What kind of history should be taken? When should a psychiatric consultation be requested? What should be done with the patient's family? What medications should be prescribed if he's released? What plans should be made for the patient's release?

History

All personnel, including the police or fire department emergency medical service rescue, should try to determine the full extent of the suicide method. Sometimes more than one method might be used, e.g., taking a small overdose of sedatives but falling asleep in the car with the engine running for 12 hours. The risk in the latter example is seen more in terms of carbon monoxide poisoning than from barbiturate overdose. If he left a note, it might indicate more serious intent. Inquiry should be made about whether or not the patient was alone and away from possible rescuers like family when suicide was attempted. The more isolated he was at that time, the greater the risk of suicide then and after discharge.

Concerned persons should ascertain how much time has elapsed since the drug was ingested or how much bleeding occurred before the patient was brought to the emergency room. This fact has obvious medical implications in terms of management.

There are important questions to ask of relatives and other contacts such as friends, co-workers and employers. For example, does the patient have firearms around the house and if so, how many and where are they kept? If family is present, the doctor should advise that firearms be removed from the home and turned over to someone else, even the police. It should be determined if the person has had firearm training and whether or not he has used it in any manner, including any suicide threat or attempt in the past. From the family or friends it should be learned whether or not the patient has been in psychiatric treatment including hospitalization in the past. They should be able to reveal by their attitude and level of concern whether or not they can be depended upon to watch and follow the patient if he is released from the emergency room.

This history should clarify the kinds of concerns this patient has. It should show what events have precipitated the suicidal act and the doctor should be as knowledgeable about them as he is about the blood level of toxic agent ingested. He must know what circumstances gave rise to the behavior and what conditions his patient will have to live with when discharged. In this regard he must know who cares about the patient living. He can only determine this through contact with friends and relatives.

If a chronic medical problem like arthritis, diabetes, pulmonary disease or cancer is at the base of the patient's depression, a good deal of relief might be offered by a frank discussion of his health problem and some referral and strategy

(Continued)

The author is director, Suicide Prevention and Drug Information Center, Detroit Psychiatric Institute, and associate professor, Department of Psychiatry, Wayne State University School of Medicine.

mapped out to see if more relief can be obtained from that condition.

Psychiatric Consultation

Psychiatric consultation should be obtained whenever closed ward in-patient care appears to be indicated. If the patient is very disturbed, psychotic, suffering from a toxic organic brain state, is unable to control impulses or has made a serious suicide attempt from a medical standpoint, a psychiatric consultation is in order. Each hospital emergency room should have a psychiatrist at least on telephone call so that the emergency room physician can discuss the case and check out what needs to be learned and what can be done in regard to the disposition of the case. Most hospitals do not have psychiatrists immediately available, at least on a 24-hour basis in the emergency room. However, one should be available for phone consultation as well as to work with the emergency room team in establishing an administrative outline of policies and clinical approaches to the suicidal patient.

He can be consulted regarding the choice of an appropriate tranquilizer as well as mental health agency in the community. If the patient can afford private care through his own resources or major medical insurance coverage, he can be referred to a staff psychiatrist or to one suggested by the local county medical society.

Patients who present more difficult clinical management problems, such as those due to a psychosis or organic brain syndrome, should be seen and evaluated by the psychiatrist. If necessary, the patient can be kept in the emergency room overnight and watched by members of the family or friends. The psychiatrist can see him the next morning under such circumstances.

The Patient's Family

As occurs with any medical emergency the family is a force with which the staff must deal. All too often they are ignored and kept in the dark. With the suicidal emergency, the doctor must reach out to the family to ascertain what happened, how they feel about the suicidal patient, what they are willing to do to help and what problems they suffer as a consequence of the suicidal experience. A prescription for tranquilizers and a recommendation to see a psychiatrist are not enough. Feelings of family members must be handled right in the emergency room. Members will feel guilty about feeling casually connected to the suicidal act because of an argument or some other family crisis or problem. They may even feel angry with the patient because of the embarrassment and the great number of suicidal emergencies with which they have been involved with this patient in the past. A doctor at the hospital must offer them some emotional support and recognition of the hardship that this emergency places on the family. He must help the family either establish a closer supervisory watch over the patient if released, or they must be dealt with in terms of admission to that or another psychiatric ward if such is indicated.

If conflicts between the family and patient are too difficult for the patient to handle and live with, it might be necessary for the patient to be admitted to the hospital for protective custody until the heat of conflict lowers. Until that happens the family cannot offer the patient the emotional support and control he requires. The doctor must ensure that the family wants the patient alive and can respond to meaningful professional advice.

Medications for Discharge

In relation to psychiatric treatment, tranquilizers without psychotherapeutic relationship and contact is a poor treatment measure. It can be a fatal mistake as well. The patient may feel that a bag full of pills is a subtle encouragement to commit suicide. It may represent a buck-passing piece of behavior by the doctor in the eyes of the patient. Tranquilizers without follow-up and further contact is like sprinkling holy water on the patient. Such a gesture is appropriate for the clergy but not for doctors in their management of the suicidal patient.

If antidepressant or anti-anxiety medication is prescribed, it should not involve more than a seven-day supply without benefit of refill. Either the patient should return for a renewal or obtain one from a mental health agency or private psychiatrist. He should be warned about sedative effect and dryness of mouth and if Mellaril is prescribed for anxiety, a male should be warned about loss of sexual libido or greater delay in ejaculation. Women given antidepressant medication should be warned about possible weight gain. If not, and the patient gains weight, it might cause a worse depression.

No sedatives should be prescribed from the emergency room contact. The doctor does not have the opportunity to get to know the patient well enough. Medications like antihistamines can be prescribed for such purposes. All medication should be labeled so that if an overdose occurs again, it can be easily identified.

Drugs like sodium amytal and phenobarbital should be avoided either as a sedative or tranquilizer. They present too great a risk for future lethal agents in a suicide attempt.

Plans for Discharge

All medical symptoms of any seriousness should be absent at the time of a patient's discharge. Comprehensive notes should appear on the chart with reference to the emergency room history, psychiatric consultation, treatment and disposition. If the patient is discharged home, a referral should

be made to the social service department of the hospital so that a follow-up phone call can be made to the patient at home the next day to check on his adjustment. Such contact would permit a determination of whether the patient had called any agency or party to whom he had been referred in the emergency room. Inquiries should be made about whether medication has been taken and what effects have been noted. The social worker can assure the patient that it will be possible to contact the hospital emergency room again and that the hospital staff is happy that it was asked to help.

Special care must be exercised in the event the patient turns out to be a member of the hospital staff or one of its relatives. Such patients should be admitted to another hospital if in-patient care is needed. One of the most difficult patients to treat is a physician since emergency room staff and psychiatrists alike assume that the doctor will exercise judgment, will be cooperative and is too medically oriented to think of suicide. Fatal mistakes are made with doctor suicides and people who are not swayed by professional identification. Staff should not handle another staff person involved in a suicidal emergency, particularly if they know him socially.

Summary

Suggestions have been presented to assist the emergency room doctor and staff to offer sensitive and effective care of the suicidal patient. History, contact with relatives, psychiatric consultation, medication policy and dispositional plans were discussed as areas of approach to the suicidal patient.

MICHIGAN DEPARTMENT OF PUBLIC HEALTH

Monthly Surveillance Report

Cases of Certain Diseases
Reported to the Michigan Department of Public Health
For the four-week period ending April 26, 1974

	1974 This 4-Week Period	1973 Same 4-Week Period	1974 Total To Above Date	1973 Total Same Date	Total Cases for 1973
Rubella	246	378	648	913	2,001
Cong. Rubella Syndrome	0	0	0	1	4
Measles	328	1,037	1,203	2,276	4,552
Whooping Cough	1	4	15	29	86
Diphtheria	0	0	0	0	0
Mumps	792	793	3,456	2,604	5,042
Scarlet Fever & Strep Sore Throat	3,519	2,504	18,705	9,585	24,467
Tetanus	0	0	1	0	2
Poliomyelitis (paralytic)	0	0	0	0	0
Hepatitis	292	314	1,359	1,313	3,872
Salmonellosis (other than S. typhi)	80	46	379	198	795
Typhoid Fever (S. typhi)	0	0	2	3	14
Shigellosis	51	42	327	171	623
Aseptic Meningitis	9	18	43	48	434
Encephalitis	9	10	19	44	163
Meningococcic Meningitis	4	7	19	18	54
H. Influenza Meningitis	10	12	46	38	89
Tuberculosis	100	162	428	542	1,380
Syphilis	222	318	1,083	1,460	4,328
Gonorrhea	2,158	2,043	10,225	9,259	31,128

Information can be supplied by the local health department on the local incidence of disease

Maurice S. Reizen, M.D., Director
Michigan Department of Public Health

Perinatal Tips

By Paul M. Zavell, MD

The following case from the files of the Wayne County Medical Society Perinatal Mortality Study Committee is presented as an aid in continuing education.

Maternal

This was the fifth pregnancy for this 32-year-old, G V, P IV (V), 0+ white mother. Pregnancy had been completely normal and she had had regular prenatal visits from the third month on. Her previous pregnancy resulted in a C-Section because of uterine dystocia. Therefore, at 39 weeks a repeat C-Section was done. She had gained 21 pounds and had a negative serology. The infant was felt by estimate before birth to be of normal size.

Fetal

A C-Section this 2.1 Kgm white female infant was noted to be quite pale, having respiratory distress, generalized edema, especially of the upper and lower extremities, and some petechiae on the face. The infant was given facial oxygen and quickly transferred from a small hospital to N.I.C.U. at a larger hospital at the age of one hour, 40 minutes with the diagnosis of "sepsis, shock and respiratory distress." Here physical exam confirmed the prior findings adding heart rate of 160/min with no murmur and liver 4 cm down. The impression was "heart failure and hydrops fetalis (?cause)."

By 2½ hours of age the umbilical vein was intubated. 10% D/W 2 mgm Edicrinic Acid I.V. and Digoxin 0.05 mgm I.M. were given. Attempts to catherize the umbilical artery failed because of the very high pressure present in this artery. Blood studies ordered were CBC, platelet count, type and cross match, Coombs test, prothrombin time, P.T.T., blood culture.

At 4½ hours of age 1 mgm of aqua Mephyton IM and 20 cc plasmonate were given. At 5½ hours of age the infant was placed on a respiratory in 30% concentration. Respiratory rate at this time was "oxygen" 60/min. She was very jaundiced and generalized petechiae were now noted. Lab studies came back showing Type 0+, Coombs 3+, Reticulocytes 50.5%, Hgb of 5.7 gm, Hct of 20, Rbc of 1.08 x 10^6, WBC of 30,000, PMN of 19, Bd of 9, Lymph of 54, Mono of 8, Eos of 03, Baso of 02, Meta of 02, Myelocyte of 03 with 239 normoblasts/100 WBC, platelets of 43,000. However, at this time no heart tones were heard. Cardiac massage was successful in reviving the infant. The laboratory now pointed out that the mother was really Rh negative to E since her blood was O-CDe/CDe. Therefore since the infant's blood was O-CDE/CDE with a 3+ Coombs we had in reality a blood incompatibility problem. 250 cc of compatible blood were used for a blood exchange that was very difficult because of intermittent cardiac arrest (reversed with intracardiac adrenalin). At 7½ hours of age and just after completion of the exchange, the infant had another cardiac arrest. Attempts at reviving the infant were unsuccessful.

An autopsy was done revealing findings compatible with typical Rh incompatibility.

Perinatal Committee Comments

1. The infant's condition of respiratory distress, paleness and hepatomegaly indicates an infant in acute distress. Among studies to be considered should be a chest x-ray (to define contours and size of heart as well as the pathologic condition of the chest) and flat plate x-ray of the abdomen in upright and flat positions (to rule out ruptured viscus, early obstruction, etc.).
2. The low hemoglobin with high reticulocyte count and increased umbilical artery pressure indicating a severe hemolytic process occurring here.
3. As this case clearly points out one must not lose sight of other possible causes of blood incompatibility other than the usual Rh negative with D or ABO. One should remember that C, E as well as the Kell and other factors can on occasion cause severe problems as pointed out here.
4. Other diagnoses to be considered here were severe congenital anemia, overwhelming infection, drug reaction (mother with salicylates, etc.), severe anemia with congenital heart disease and congenital spherocytosis.

Doctor Zavell is chairman of the Perinatal Mortality Study Committee of the Wayne County Medical Society and a member of the Neo-Natal and Hospital Care Committee, Michigan Chapter, American Academy of Pediatrics.

Stabilizing the Colles Fracture

By Robert W. Augustine, MD, Detroit

The Colles fracture[1] is frequent, generally easy to reduce[2] but difficult to stabilize. This structure is basically unstable and needs some kind of support beyond a position cast. Cast immobilization is usually applied, but this does not supply traction or prevent the fragments from collapsing under the thrust of the carpus, particularly the force engendered by finger motion necessary to retain essential function. Cancellous bone about the lower radius gives rise to unstable fragments with fracture, particularly with osteoporosis present in the aged, diabetic or alcoholic. Even in the normal adult the structural stability of the lower radius has been destroyed by the nature of the fracture, bone absorption and shortening may ensue even without initial deformity. Traction on the fingers or pins placed in the ulna or metacarpals can lead to infection, loss of reduction and stiff fingers. The final result depends upon full finger function, shortening of the radial styloid and dorsal declination of the radial facet notwithstanding. An anatomical product is preferable. With comminution of the radial facet accurate reduction must be maintained to avoid subsequent radiocarpal arthritis. Figure 1 shows the fracture lines in a Colles fracture all or some of which may occur, either with or without displacement.

The radial styloid fragment is always available for pin fixation due to penetrating ligamentous fibers associated with the annular ligament stabilizing the thumb extensor and abductor. Reduction of the fracture should proceed by squeezing the wrist laterally to replace the distal radio-ulnar fragment. Apply traction and ulnar deviation and flexion to regain length, thrust down on the dorsal buckle fragment and the lunate fragment *(if displaced).* Test the general morphology. Have an assistant hold the hand in traction flexion

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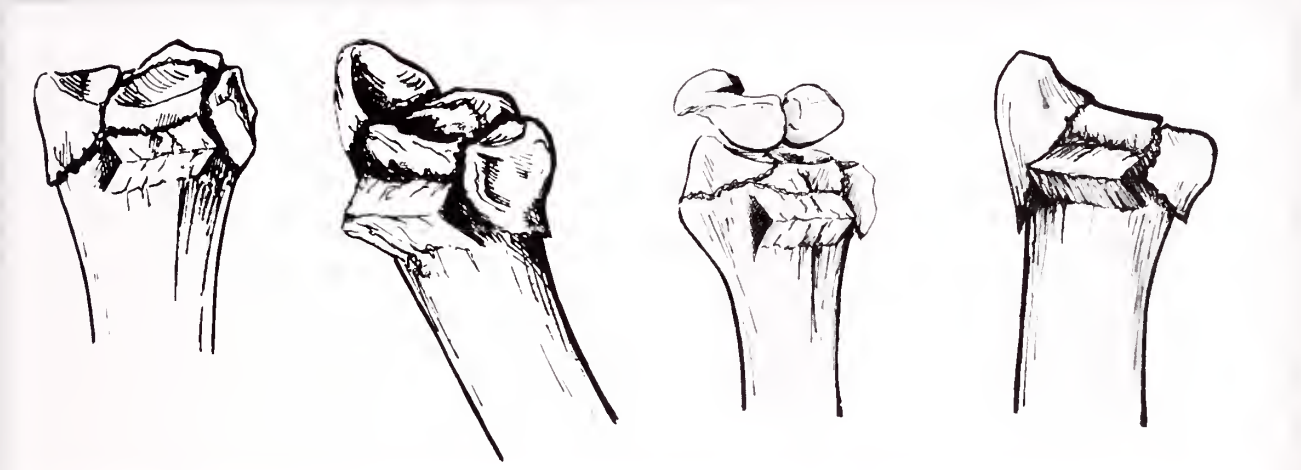

Figure 1: The usual fracture lines of a Colles fracture. Part or all of these fractures may be evident. Displacement may or may not occur. Types include the radial styloid, the lunate, the distal radio-ulnar, the dorsal buckle and the transverse radial fractures.

The author notes that others have probably used this technique. He formerly served as orthopedist and chief of surgery, in 1973, at St. Joseph's Hospital, St. Joseph, Mo. He presently is in practice in Detroit and is consultant to the Detroit Industrial Clinic, Warren.

Figure 2: Placement of stabilizing pins between the short and long thumb extensors in the radial styloid.

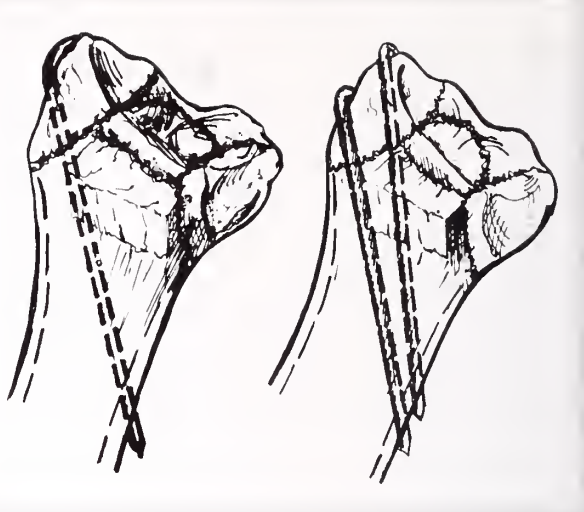

Figure 3: Stabilization of the radial styloid on the proximal radial cortex, fending off the thrust of the carpus on the radial facet.

and ulnar deviation over a sand bag. A one centimeter incision over the tip of the radial styloid will reveal the open bone area between the thumb abductor and long extensor tendon *(Figure 2).* Avoid the tendon sheaths and the radial sensory nerve. Place one 0.62 Kirschner wire through the tip of the radial styloid with a power drill and direct it then through the proximal radial cortex *(Figure 3).* As resistance fades and the pin perforates the cortex, stop the drill. Test stability, obtain portable x-ray's AP, lateral and oblique of the distal radial facet. If position is satisfactory, insert another Kirschner wire parallel with the first, bend the Kirschner wires and cut off short and twist so the hooks are distally placed. Avoid hooking a vital structure. Close wound. Apply a dorsal skin tight splint no wider than three inches from the metacarpal-phalangeal joints to just distal to the antecubital fossa, with the wrist moderately flexed and internally rotated. Apply circumferential sheet wadding and a shell cast using one three inch roll and a short volar splint. Stop the cast short of the volar palmar crease. Do not put plaster in the thumb-index webb. Teach patient metacarpo phalangeal joint and inter-phalangeal joint flexion and extension, pro and supination and elbow and shoulder motion.

Supply sedation for the first several nights. Insist on elevation of the hand above the cardiac pump. Do not use a sling. The pins can be removed after six weeks. The amount of stability supplied by two Kirschner wires plus a cast provides a simple method of holding reduction in a Colles fracture.

References

1. Colles A: On the fracture of the carpal extremity of the radius. *Edin Med Surg J* April, 1814.

2. Augustine R: The Colles fracture. *Missouri Med* **69:** 6, 1972.

INFORMATION FOR CONTRIBUTORS

1. Address scientific manuscripts to the Publication Committee, Michigan State Medical Society, 120 W. Saginaw St., East Lansing, Mich. 48823. Submit original, double-spaced typewritten copy and two carbon copies or photo copies on letter size (8½ x 11 inch) paper. On page one, include title, authors, degrees, academic titles and any institutional or other credits.

2. Authors are responsible for all statements, methods and conclusions. These may or may not be in harmony with the views of the editorial staff. It is hoped that authors may have as wide a latitude as space available and general policy will permit. The Publication Committee expressly reserves the right to alter or reject any manuscript, or any contribution, whether solicited or not.

3. Illustrations should be submitted in the form of glossy prints or original sketches from which reproductions will be made by *Michigan Medicine.*

4. Articles should ordinarily be less than four printed pages in length (3000 words).

5. References should conform to *Index Medicus,* including, in order: Author, title, journal, volume number, page and year. Book references should include editors, edition, publisher and place of publication, as well.

6. The editors welcome, and will consider for publication, letters containing information of interest to Michigan physicians, or presenting constructive comment on current controversial issues. News items and notes are welcome.

7. It is understood that material is submitted for exclusive publication in *Michigan Medicine.*

8. Letters and articles for the news section should be sent to the Managing Editor, *Michigan Medicine,* 120 W. Saginaw St., East Lansing, Mich. 48823, by the fifth of the month preceding the month of publication.

Commentary

Service for Fee *Not* Fee for Service

By Reuven Bar-Levav, MD, Detroit

The idea of service has fallen into a great deal of disrepute in latter years. Time was, not so long ago, when both individuals and groups often took a great deal of pride in their ability to provide good, dignified service to others, fully realizing that in so doing their humanity was not diminished in any way. The good servant saw himself and was seen by others as making a real contribution toward the orderly conduct of daily living, and his status in society was secure. Even today, official letters written by the British Government bear on top the words "On Her Majesty's Service." Servants and their masters *(this term did not always denote domination and unfairness)* realized that they both needed each other for their existence and that they had an inter-dependency from which both benefited. They often liked each other, respected each other and truly felt at a loss without each other.

Twentieth century mass society living in huge megalopolis centers has brought an immense change in our value systems. Even neighbors are often suspect. Distrust and fear of strangers are constant companions, whether we live within the city or in the suburbs. The increasing crime rate is only the obvious rationalization of this fear and its immediate, but not ultimate, cause. As we trust less, we teach our children to be wary of unknown situations and people, and in effect we are daily paying the high price of human isolation for our security.

Human Qualities Lost

As a consequence, many important human qualities of the past have been lost. Not only is gracious living at a slow pace mostly a nostalgic memory, but also open friendliness, warmth and good service have practically disappeared. The term "mastery," which in the past denoted competence and an ability to perform well in one's field, now often is associated with disrespect and unfair treatment of others. In the social upheaval in which we find ourselves, the idea of democracy is also being grossly distorted. It is often misinterpreted as meaning that we all are the same, when really it means that we are equal in our humanity and rights. Thus, the idea of being a servant to another person is not interpreted as a freely-chosen

Dr. Bar-Levav

professional role, but instead is seen as demeaning to the servant and as robbing him of self-respect and dignity. Society as a whole is the loser. Every day each of us comes across many situations where service is given begrudgingly, angrily and without good will, beginning with the pouring of a cup of coffee in a restaurant and the repair of our TV set to the quality of service one finds in a hospital.

All service professions are similarly the losers. Household workers and other lower paying service professions are disappearing, and it is extremely difficult to find competent help of this type. Electricians, gardeners, drivers, painters, seem to offer their services reluctantly and almost expect us not only to pay them fairly for their honest work, but

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Michigan Medicine's new Commentary page will offer physicians and others the opportunity to express opinions on issues in medicine. Contributions are invited and should be submitted to Commentary, *Michigan Medicine,* 120 W. Saginaw St., East Lansing, Mich. 48823.

The views expressed here are those of the author and do not represent positions of the Michigan State Medical Society or opinions of the editors of *Michigan Medicine.*

also to be grateful for the fact that they are willing to render it. Servicemen more often than not adopt an attitude of arrogance and unreasonableness and act as if they are doing us a favor by serving us (which is now called servicing) when, in fact, that is what they freely contract with us to do.

No Profession Escapes

The higher paying and more prestigious service professions, such as accounting, law and medicine, have not escaped a similar change in their basic attitude towards others. Historically, this obviously was not so. In the past, the doctor was always on call, and the sick patient knew that he could count on his physician to render him service whenever he needed it. To be a physician was a calling, not a profession, a holy trust that was enveloped in symbols and ceremonies that expressed the high regard for the physician who was willing to assume freely the heavy responsibility for the lives of others. It is natural, therefore, that physicians were usually the most respected citizens in their communities. They not only earned a good living but were generally looked upon as wise men of high ethical character whom others wanted to emulate and actually looked up to.

Fee for service so rendered was rarely questioned. The doctor making a house call was given a fresh, clean towel for his hands as well as reverence and gratitude for his devotion. The fee was usually the least the patient could do in return for the services of a physician. Those who had more paid more, but it was not uncommon for a physician to come home carrying a chicken or other products made by the patient or members of his family. This indeed is the origin of the sliding scale of fees in medicine.

The overuse of words turns them into cliches and causes them to lose their meaning. Thus, the words "Fee for Service" have also undergone an inflationary change that reduced their value. When used by physicians, are they meant in their dictionary sense? Are we really happy in our role as servants to our patients? Does our attitude convey to them our acceptance of this position?

The hue and cry for the elimination of the fee for service system may in fact be to a large extent a result of the fact that we often do not behave as servants, true and loyal servants, to our patients. Instead, we appear as busy, self-important and sometimes arrogant masters. As physicians are we not sometimes disrespectful of the fears and sensitivities of our patients and usually disrespectful of their time?

Demands for Changes

The demands for changes in the delivery system of medical care may well have deeper and different roots than economics alone. Underneath it all may well lie the fact that basically we often are not providing service for which we expect a fee, but, instead, convey the impression through our busy practices that we are really out for the fee and somewhat hurriedly and unhappily also provide the service.

This obviously is a distortion of reality. In fact, the patient is our employer and we have the responsibility to faithfully render service at its best. In taking the Oath of Hippocrates, we have sworn to live a life that has many elements of devotion and self-sacrifice in it. We freely undertook an obligation to prefer the patient's health to our convenience. Although we are entitled to live in comfort and economic well-being, hopefully this was not the main reason for our going into medicine and is no reason for remaining there.

It would indeed have been wonderful, but remarkably unusual, if the majority of physicians could live up to this ideal, which is in the best traditions of Medicine. Unfortunately, it makes no sense to expect that under the changed value systems and in the prevalent isolation of our society, physicians would be so different and so much better than other people. Although our calling imposes special burdens on us individually and as a group, we are nonetheless subject to the same weaknesses that others are subject to. We are different in our education, role and responsibilities — but not in our humanity. Physicians are subject to the same temptations as non-physicians. Those who complain about the short-comings of the medical practitioners will have to realize that they are not only unfair but also unrealistic.

It would be of immense practical importance for those who advocate a change in the delivery system of medical care to remember that no administrative change could basically alter the nature of Man, even if that man is a physician. It is nonetheless our responsibility, individually and collectively, to hold the hallowed traditions of Medicine in front of us at all times. Though we are bound to fail and fail again in our attempts to live up to the ideal, we must always attempt to remember that medicine exists to provide a service for individuals in pain and need. Defending the virtues of the private practice of Medicine might be easier and more successful if it were seen as providing service for a fee rather than the usual "Fee for Service."

E. Gordon Yudashkin, MD, Steps Down From Michigan Mental Health Post

By Donald W. Martin, MD, Pontiac, for the Michigan Psychiatric Society

After a colorful eight years in Michigan, marked by a rapid rise up the administrative ladder, E. Gordon Yudashkin, MD, announced his resignation as state mental health director and his return to New York State, effective June 1.

Doctor Yudashkin came to our state in 1966 to assume the post of medical superintendent of Northville State Hospital, following years of broad and diversified experience in both private and public psychiatry. He studied and served as assistant lecturer at the American Institute of Psychoanalysis in New York and also founded, and for five years directed, the large state-operated Brooklyn Aftercare Clinic, with a caseload of 2,500. He continued the pursuit of his interest in community mental health, founding the Nassau County Psychiatric Consultation Clinic, which he then headed for four years prior to his departure for Michigan.

Dr. Yudashkin

Many Changes

At Northville State Hospital he organized many sweeping changes, including decentralization into a team unit system, the establishment of the first young adult unit in the state *(involving special programming for the 17-21 age group)* and the first commuity aftercare center for the hospital. During the 2½ year period, the hospital's census decreased from 2,150 to 1,425. At the same time, the waiting list for admission was completely eliminated and the annual admission rate rose from 1,000 to 2,100.

From 1968 to 1970, under William Anderson, MD, Gordon Yudashkin served in the Department of Mental Health as program director of the Division of Community and Hospital Services. Then, with Doctor Anderson's resignation in May 1970, he was named acting director of the department and, in August of that year, permanent director, by Governor Milliken.

During the Yudashkin years the state's mental health program moved rapidly into the expansion of community-based services. Now, practically every Michigan citizen has access to a spectrum of county-funded community mental health services, currently able to treat more than 125,000 patients yearly.

Waiting List Drops

During the period 1970-1974, the number of institutionalized mentally retarded persons declined by 4,000; and the huge, 1,400 waiting list for admission was almost entirely eliminated.

Also thanks to improved treatment methods and the expanded community placement program, the hospitals for the mentally ill, while admitting more patients than ever, kept them for much shorter periods and were able to eliminate some 5,000 beds.

An idealistic, dynamic man, Gordon Yudashkin is at times blunt and outspoken to an extreme degree because he cares so deeply about the individual patient and is so impatient to see progress in the field of mental health. His many friends and colleagues join me, I know, in wishing him success in the new challenges he will face as a regional mental health director in the State of New York.

McCormick Place, on Chicago's lakefront, will be setting for most programs during AMA Annual Convention.

Strong Michigan Attendance Expected at AMA Event

Continuing education courses and scientific discussions and exhibits are expected to attract attendance by several hundred Michigan physicians at the American Medical Association's scientific program June 22-26 in Chicago.

Thirty-one continuing education courses will be offered, along with programs planned by AMA section councils. General sessions are scheduled on "Obesity: The Cause and Management" and "Office Treatment of Hypertension." Most programs will be held at Chicago's McCormick Place where scientific exhibits will be installed.

The 1974 Annual Session of the AMA House of Delegates opens June 22 in the Palmer House Hotel.

The complete scientific program was published in the April 15 issue of the *Journal of the American Medical Association.* Physicians attending scientific sessions only have been asked to register at McCormick Place.

Key Roles

Several Michigan physicians will have key roles in scientific sessions. James Muldoon, MD, of Grand Rapids, is a member of the faculty for a course on "Office and Hospital Management of Anorectal Disease," and Thomas F. Dutcher, MD, of Royal Oak, is course director for "Morphology of Smears and Bone Marrow Sections."

Laurence P. Skendzel, MD, of Traverse City, is co-director for a course on "Quality Control of Laboratory Procedures in the Physician's Office." Norman D. Nigro, MD, of Detroit, will moderate a panel discussion on constipation. A presentation on "Atopic Disease and Serum Immunoglobulin E" will be made by a group of physicians from Ann Arbor, including Henry E. Jones, MD; Joyce C. Inouye, MD; Joseph L. McGerity, MD, and Charles W. Lewis, MD. Thomas K. Burnham, MD, of Detroit will present "The Upper and General Epidermal Cytoplasmic Immunofluorescent Patterns."

Ray E. Helfer, MD, of East Lansing, will moderate a panel on special problems in handling child abuse.

Harold F. Falls, MD, and Richard A. Lewis, MD, both of Ann Arbor, will present a discussion on "Ocular Manifestations of Hypercupremia." "Low Hyperbaric Therapy in Treatment of Leg Ulcers" is the topic of Stanley Olejniczak, MD, of Eloise. Ronald L. Krome, MD, of Detroit, will take part in a panel discussion on common problems in the office, emergency room and hospital.

Panelists

Raymond W. Waggoner, MD, of Ann Arbor, will be among panelists for a symposium on the physician as marital and sexual counselor, and Stephen N. Rous, MD, of East Lansing, will discuss diagnostic methodology in a symposium on carcinoma of the prostate. John G. Wiegenstein, MD, and Eugene C. Nakfoor, MD, both of Lansing, are to participate in a symposium on the flow of the acutely-ill patient. Neal A. Vanselow, MD, of Ann Arbor, is a discussionist for a symposium on initial management of the acutely-ill patient. Participants in a motion picture symposium on abdominal trauma include William R. Olsen, MD, of Ann Arbor.

Michigan physicians involved in preparation and display of scientific exhibits include Franklin V. Wade, MD, of Flint; E. L. Quinn, MD, Frank Cox, Jr., MD, Evelyn Fisher, MD, Tom Madhavan, MD, Keith Burch, MD, Erwin Haas, MD, Luciano Dias, MD, Edwin R. Guise, MD, and Thomas Foerster, MD, all from Henry Ford Hospital, Detroit; Doctor Olejniczak and Andrew Zielinski, MD, from Wayne County General Hospital, Eloise; John N. Wolfe, MD, Hutzel Hospital, Detroit; Edward Hoffer, MD, William H. Johnson, MD, Howard Wharton, MD, and Gerald A. Wyker, MD, all of Kalamazoo and Charles Frey, MD, Paul James, MD, George Johnson, MD, and James Mackenzie, MD, all of East Lansing.

Doctor Sweeny Chairs Michigan AMA Delegation

Donald N. Sweeny, Jr., MD, of Detroit, again serves as chairman of the MSMS delegation to the AMA House of Delegates meeting opening June 22 in Chicago. Other MSMS delegates are John J. Coury, MD, of Port Huron; James C. Danforth, Jr., MD, of Grosse Pointe Woods; George W. Slagle, MD, of Battle Creek; Otto K. Engelke, MD, of Ann Arbor; Paul T. Lahti, MD, of Royal Oak; John W. Moses, MD, of Detroit, and Robert E. Rice, MD, of Greenville.

Alternates are Marjorie Peebles Meyers, MD, of Detroit; Vernon V. Bass, MD, of Saginaw; Robert C. Prophater, MD, of Bay City; Kenneth J. Ray, MD, of Grosse Ile; Frank B. Walker, II, MD, of Grosse Pointe Park; Richard J. McMurray, MD, of Flint; Brooker L. Masters, MD, of Fremont, and Donald T. Anderson, MD, of Kingsford.

Michigan physicians serving as specialty section delegates and alternates include Harold F. Falls, MD, of Ann Arbor, ophthalmology; George H. Koepke, MD, of Ann Arbor, physical medicine and rehabilitation; Clarence S. Livingood, MD, of Detroit, dermatology, and Chris J. D. Zarafonetis, MD, of Ann Arbor, clinical pharmacology and therapeutics.

Doctor Falls chairs the reference committee on rules and order of business for the meeting.

Dr. Sweeny

Dr. Coury

Dr. Danforth

Dr. Slagle

Dr. Engelke

Dr. Lahti

Dr. Moses

Dr. Rice

Dr. Falls

Dr. Koepke

Dr. Livingood

Dr. Zarafonetis

Michigan to Offer Two Resolutions to AMA

The suggestion of MSMS President Brooker L. Masters, MD, that the medical profession use television to express its views to the public will be put before the AMA House of Delegates by the Michigan delegation in late June.

A second resolution to be put before the AMA's Annual Session beginning June 22 in Chicago by the MSMS delegation calls for action on residency programs in emergency medicine.

Following are texts of the Michigan resolutions:

1. Whereas, the medical profession is continually buffeted by unjust criticism pertaining to many of the economic and social problems of our nation, and

Whereas, many of these critics have access to the TV media, and

Whereas, similar access on a non-paid basis is denied to organized medicine; therefore be it

RESOLVED: That the AMA staff, under the guidance of the Board of Trustees, develop an ongoing program of public messages presenting the views of practicing physicians to be placed with major TV stations as paid announcements, and be it further

RESOLVED: That the AMA urge each individual member to voluntarily contribute to a special AMA fund for such AMA messages concerning current medical or health care issues.

2. Whereas, large numbers of physicians have dedicated their careers to emergency medicine, and

Whereas, certain medical schools have established academic departments in emergency medicine, and

Whereas, increasing numbers of universities and teaching hospitals have recognized the need for training physicians in this field and at this stage 23 have, in fact, instituted residency training programs to fulfill this need, and

Whereas, it is imperative that the quality of these new residency training programs be assured, and

Whereas, the American Medical Association Council on Medical Education has long been recognized as the guardian of the quality of medical care, and

Whereas, the Council on Medical Education of the American Medical Association has had an official petition for establishment of a residency review mechanism for their consideration since November of 1970; therefore be it

RESOLVED: That this House of Delegates of the American Medical Association request the Council on Medical Education to expedite (1) adoption of the Essentials of a Residency Training Program in Emergency Medicine, (2) establishment of an approval mechanism for emergency medicine residencies, (3) preparation of a status report on this activity to be delivered to the House of Delegates at the Annual Meeting in November.

Medical Assistants Convene

National officers of the American Association of Medical Assistants who took part in annual convention of AAMA, State of Michigan, held recently at the Detroit Hilton Hotel are, seated from left, Betty Lou Willey, CMA, of Port Huron, president-elect; Marian G. Cooper, CMA, of Pittsburgh, president, and Dorothy Hartel, of Baltimore, secretary-treasurer. Standing is Nelda Gasperson, CMA, president of newly formed Macomb County Chapter, AAMA, State of Michigan.

New AMA Representative Assigned for Michigan

Guy D. Beaumont, Jr.

Guy D. Beaumont, Jr., has been appointed American Medical Association field service representative for Michigan and three other states, replacing James Imboden, who has become executive director of the Academy of Medicine of Columbus and Franklin County (Ohio).

Beaumont, who will provide services to Ohio, Virginia and West Virginia as well as Michigan from offices in Columbus, Ohio, is a graduate of Antioch (Ohio) College and has been with the AMA since 1972.

Breast Cancer Detection Demonstration Project Begins at University of Michigan Hospital

By Barbara Threatt, MD, Ann Arbor

Breast cancer is the leading cause of cancer incidence and cancer death in American females. There will be approximately 90,000 new cases of breast cancer in the U.S. in 1974; approximately 33,000 deaths will occur this year from breast cancer. In Michigan an estimated 3,800 new breast cancer cases will occur in 1974 with 1,400 deaths.

The overall statistics on breast cancer are grim. In fact, there has been essentially no improvement in the survival of breast cancer patients over the last 40 years. This is in striking contrast to the sharp decrease *(over the same period)* in cancer deaths in patients with carcinoma of the uterus and cervix. This decrease in uterine cancer deaths is attributed in major part to the earlier detection of these cancers by means of the Papanicolaou smear.

Detection Difficult

No comparable test exists for the detection of breast cancer. We have several modalities for testing the breast but none which gives us the cellular information that a Papanicolaou smear does. In essence, we use the woman herself as a screener *(i.e., most breast cancers are found by the woman and are 2 cms. or over in size, and 50 per cent of these already have axillary metastases at the time of discovery).* After an abnormality is detected by the woman or her physician other examinations are performed. These examinations are mammography *(film or xeromammography)* and thermography.

Mammography is now a well-established and accepted method of breast examination. With recent innovations of examination *(Dupont's Lo-Dose film and xeromammography)* better detailed films requiring lower radiation dosage to the breast are possible. Accuracy of mammography has been reported from 70-95 per cent depending upon the type of patients and the mammographer. In general, mammography has an accuracy of 70-80 per cent; in combination with a careful physical examination diagnostic accuracy for a breast mass is approximately 96 per cent.

Thermography is a new technique for breast examination; in this technique the infra-red radiation from the breast is photographed. Interpretations of thermograms are based on the observations that *any* site of increased metabolic activity will produce increased amount of infra-red radiation. These areas of increased infra-red radiation appear as a "hot spot" on a thermogram. An abnormal or positive thermogram does not indicate cancer; rather, it indicates that there is a focus of increased metabolic activity within the breast. This focus can be fibrocystic disease, and abscess, or cancer. Thermography offers promise in the evaluation of women for breast abnormalities since it does seem to select out women who are in a high risk group. At the present time a thermographic examination without a physical examination and a mammogram is a useless examination. Further documentation is required to prove that a thermogram alone is sufficient as a breast screening examination. Thermography also has the disadvantage that the false positive rate is high *(15-25 per cent)* since any area of increased metabolic activity can produce a "hot spot." Two distinct advantages of thermography are the lack of radiation exposure and the simplicity of the examination.

New Project

In view of the above findings, the American Cancer Society and the National Cancer Institute have designated 20 sites throughout the United States as Breast Cancer Detection Demonstration Projects. The University of Michigan has been chosen for one of these sites, with facilities to be located at 396 W. Washington St., Ann Arbor. The demonstration project will open on July 8.

These 20 projects are established for several purposes, but especially to test the efficacy of the various modalities (physical examination, mammography and thermography) of breast examination. Other purposes will be to evaluate only asymptomatic women, test the effectiveness of local American Cancer Society Chapters in providing screenees, scheduling, etc., obtain very detailed health histories on all screenees and teach breast self-examination to all screenees.

The project will function as follows: Each screenee will agree to undergo an initial thorough health history evaluation and a breast examination *(mammography, thermography and physical*

(Continued)

The author is assistant professor of radiology at the University of Michigan Medical School.

examination) with follow-up examinations annually for a minimum of five years. All examinations will be without charge. To qualify as a screenee a woman must be *asymptomatic* for breast symptoms or masses and within the ages of 35-74 years. Women with masses, pain, discharge or other symptoms are not acceptable as screenees. Local Americal Cancer Society chapters will serve as the focus for scheduling of screenees. Publicity aimed at both the lay public and the medical profession will inform both groups as to availability of the testing, procedures, etc. Any interested woman should contact her local American Cancer Society for a screening appointment. Each demonstration project will examine 5,000 women per year or approximately 20 women per day, who will undergo a physical examination, mammography and thermography. Intimate contact will be maintained with our local Washtenaw Medical Society and other county medical societies throughout the state. Each patient must supply a referring physician's name. Since some patients will not have personal physicians a roster of physicians from each county will be maintained to assure that each screenee will have a choice in designating a physician. Each screenee's physician will receive written notification of the screenee's examinations and results. If examinations are positive for malignancy the screenee will be instructed *(by mail)* to contact her physician; the physician will also have received a detailed written account of the examinations, the results and our recommendations.

To Follow Patients

Follow-up of patients will be an integral part of the project. Most screenees will be asked to return for an annual examination. However, about 25 per cent of the screenees will have abnormal thermograms and/or mammograms. These women will be seen at shorter intervals for repeat evaluation. Follow-up information concerning any biopsy or mastectomy performed on screenees will also be actively sought by the project. This will be carried out by letter and phone contact. We will especially need cooperation from the pathologists who will examine the biopsy and mastectomy specimens. Our pathology form is quite detailed so we can only ask for help and support in supplying this information.

The Breast Cancer Detection Demonstration Project will offer the women of Michigan an opportunity to participate in a reciprocal arrangement. They will obtain as complete a breast evaluation as is available by present methods and we *(at the project)* will obtain detailed historical information, mammograms and thermograms on approximately 5,000 women. The results from the Michigan project, along with those from the other 19 projects will be compared statistically. We hope to obtain from all these examinations and statistics some conclusive information regarding the possibility and feasibility of true screening for breast cancer. In this way, perhaps, we can eventually produce a dramatic decrease in the breast cancer death rate by finding the cancers at a very early stage and, as we understand breast cancer and all its mechanisms better, perhaps we can even decrease its actual incidence in our female population.

Coller-Penberthy-Thirlby Conference Set

A distinguished faculty including several out-of-state physicians will present the program at the 54th annual Coller-Penberthy-Thirlby Medical Conference July 24-26 at Traverse City.

This conference is sponsored by the medical and administrative staffs of Munson Medical Center.

A. James French, MD, chairman, Department of Pathology, University of Michigan Medical Center, serves as program chairman and he has selected more than 30 physicians in different specialties to lead the discussion on highly topical subjects which include "Views on Cardiovascular Surgery," "The Status of Arteriography" and "Trends in the Use of Colonoscopy."

The faculty is selected from medical centers across the country. Invited guests include Brooker L. Masters, MD, MSMS President; Robert D. Coye, MD, Andrew D. Hunt, MD, and John A. Gronvall, MD, deans, respectively, of the medical schools of Wayne State University, Michigan State University and the University of Michigan. Doctor Gronvall will be the toastmaster for the Thursday evening dinner. Other guests include C. Gardner Child, MD, of Ann Arbor; Lester R. Dragstedt, MD, of Gainesville, Fla.; Edgar A. Kahn, MD, of Ann Arbor; Reed M. Nesbitt, MD, of Chicago, and Harry A. Towsley, MD, of Ann Arbor.

Three hundred physicians are expected to attend.

Education

Michigan Council of Deans Promotes Cooperation in Medical Education

By Ralph E. Lewis, MPH

A new spirit of cooperation has appeared in medical education in Michigan. It is evidenced in the Michigan Medical Schools Council of Deans. Although the deans of some medical schools in other parts of the country get together periodically, the Michigan Medical Schools Council of Deans is the only such organization in the United States with a full-time, paid staff.

The council was established to initiate innovative, creative communication channels between the medical schools in Michigan, through the medical deans, and to encourage cooperative efforts in program areas and long-range planning. This is being accomplished. Future plans call for ways to share new audio-visual and other instructional programs developed by the respective schools, a coordinated program for continuing medical education and continued coordination of long-range planning of enrollments, facilities and educational programs.

In 1971 the deans of the then three medical schools — University of Michigan Medical School, Wayne State University School of Medicine and Michigan State University College of Human Medicine — met for a joint appearance before the House of Representatives' Appropriations Committee. Discussion centered on ways the medical schools could work together and coordinate their efforts, particularly in areas with statewide application.

The three deans, Robert Coye, MD, Wayne State University School of Medicine; John Gronvall, MD, University of Michigan Medical School, and Andrew Hunt, MD, Michigan State University College of Human Medicine, began to meet periodically and were joined by Myron Magen, DO, dean of the new Michigan State University College of Osteopathic Medicine.

Director Appointed in 1973

The Council of Deans was officially organized in February of 1973 with the appointment of a full-time executive director and the establishment of an office. The deans, their associate deans and other key staff members, meet with the council director every two months.

The council works on problems and programs at the state and national level that can be solved better collectively than individually. The council also serves as the entry point for requests to the medical schools for cooperative projects and other joint assistance.

One of the major achievements of the Council has been establishing, in cooperation with the Association of American Medical Colleges, a pilot matching program for students applying to medical schools in Michigan and California. With some 40,000 applicants filing almost 400,000 applications for approximately 14,000 first-year places in the nation's medical schools, a more rational approach to admissions is needed. In Michigan last year, more than 10,000 applicants applied to the three allopathic schools for approximately 550 first-year places; most of these applicants applied to all three schools. In addition, the MSU College of Osteopathic Medicine had some 1,300 applicants for 64 places.

(Continued)

The author is executive director of the Michigan Medical Schools Council of Deans. He presently serves as president of the Michigan Public Health Association and chairman of the Great Lakes Action Group of the American Public Health Association's Action Board.

To Compare Procedures

The pilot program in the three MD producing schools will be run in parallel with the schools' regular admissions procedure. The results of the "match" can then be compared with the class the schools actually accept. The aim of the program is to reduce the months of work by admissions committees now spent in reviewing applicants who have not only applied to the three Michigan schools, but to an average of seven schools, in the hopes of being picked by one. Such a program would also benefit the student by matching him with the schools which he has ranked highest on his list, thus reducing the uncertainty and anxiety surrounding the application process.

An Early Decision Program (EDP) was instituted last spring by the three allopathic schools. This is designed to speed up and simplify the admissions process by allowing a medical school applicant to request and receive an early decision from the medical school of his first choice before seeking acceptance elsewhere. The applicant knows by Oct. 1 whether he or she has a place in the school of his choice, and, if accepted, need not spend the time, money and effort of applying to other schools.

The MSU College of Osteopathic Medicine is not a participant in this program, but together with other colleges of osteopathic medicine has been discussing a national unified application service which might include an early decision program.

The council is working closely with health professions advisors in Michigan colleges and sponsors what has become an annual event — a Health Professions Advisors' Day. This event, rotated to a different medical school each fall, is designed to help the premedical advisor obtain a better understanding of Michigan medical schools, their application processes, the importance of letters of recommendation, curriculums, etc.

National Organization

Communications each year are sent to advisors, both from the Council of Deans and from the Association of American Medical Colleges. A national organization of advisors in health professions is being formed, and the Michigan council will be participating in activities of this group also.

One of the biggest cooperative efforts is the Michigan Senate-funded study on the cost of medical education. The medical schools have been working together for over a year on the study, conducted by a California group. It should be completed this spring.

Although a number of studies have been carried out nationally, this Michigan cooperative effort appears to be the first of its kind.

An October, 1973, report by the Association of American Medical Colleges shows that the cost per student in programs leading to an MD degree ranges from $16,000 to $26,000 depending on the school, its program and its location.

The Michigan study hopefully will create a system for understanding ways in which the medical education activities of the four state-supported medical schools are being financed and the products which this investment creates.

A new project is attempting to get more accurate information on what happens to graduates of Michigan medical schools. Where do they go for internship and residency? Where do they end up practicing? In addition, similar questions are being asked about the physician manpower pool in Michigan. Where did physicians who are practicing in Michigan receive their medical education? Where did they do their graduate training? Answers to questions like these will aid the schools in planning future educational programs and will help the legislature to make sound judgements in financial planning.

Close to State Government

The Council of Deans has a close working relationship with the Governor's Office of Health and Medical Affairs. The four medical school deans serve on the State Health Planning Advisory Council, the major advisory group to the office, and Dean Hunt is chairman of the advisory council.

Currently the four schools are aiding the Governor's Office of Health and Medical Affairs in conducting a series of investigations which will result in a report and recommendations to the governor on a new health care system for the Michigan Department of Corrections. A technical advisory committee, composed of a representative from each of the four medical schools, is aiding in the development of a program to conduct a health assessment of a sample of the inmate population. Data on health needs of inmates will be coupled with the study staff's report on facilities and resources in the state's prisons to form the basis for the recommendations to the Governor.

WSU Dedicates New Ophthalmology Center

Dedication ceremonies for a new 2.4 million dollar building for Wayne State University's Kresge Eye Institute were held May 3 at the new structure in the Detroit Medical Center. The institute, established in 1948 and affiliated with WSU since 1950, has been located at 1400 Chrysler Freeway in Detroit since 1972. The institute is devoted to patient care, research in ophthalmology and the training of eye specialists. Robert S. Jampel, MD, chairman of the department of ophthalmology at the WSU School of Medicine, is director of the Kresge Eye Institute.

The post-T&A patient:
another type for Tylenol®
(acetaminophen)

When the post-T & A patient requires an analgesic, a new problem arises. Hemorrhagic tendencies following the use of aspirin after tonsillectomies have been reported.[1,2] In a patient who "...has recently undergone a surgical procedure or has another underlying hemostatic defect, aspirin ingestion may cause significant bleeding....Aspirin is absolutely contraindicated in such situations. Acetaminophen...could replace aspirin in these instances."[3]

The post-T & A patient is only one of several 'types for TYLENOL'—that is, patients who should avoid aspirin. Considering all of them, wouldn't it provide added safety (as well as added convenience) to recommend TYLENOL (acetaminophen) routinely for simple analgesia?

References: 1. Reuter, S. H., and Montgomery, W. W.: Arch. Otolaryng. 80:214-217 (Aug.) 1964. **2.** Osol, A., et al., ed.: The United States Dispensatory and Physicians' Pharmacology, ed. 26, Philadelphia, J. B. Lippincott Co., 1967, p. 171. **3.** Schwartz, A. D., and Pearson, H. A.: J. Pediat. 78:558-560 (March) 1971.

Precautions and Adverse Reactions: If a rare sensitivity reaction occurs, the drug should be stopped. TYLENOL (acetaminophen) has rarely been found to produce any side effects.

Elixir, 120 mg./5cc. (alcohol 7%).
Drops, 60 mg./0.6cc. (alcohol 7%).
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MICHIGAN'S HEALTH:

An Analysis of Status, Issues and Needs in the 1970s

By Kurt Gorwitz, ScD

Introduction

The relationship of population growth and composition to the need for and utilization of health related resources has been repeatedly discussed in the literature. We here document and analyze Michigan's current and anticipated future population trends and consider their implications and impact.

Michigan's population increased 1,052,000 between 1960 and 1970, from 7,823,000 to 8,875,-000. This increase, about 1.3 per cent per year, gave Michigan, the seventh largest state in population, the fifth biggest growth rate among the ten major states. Almost all of this rise was due to an excess of births over deaths, with the number of people moving into and out of the state virtually in balance. However, most of those migrating to Michigan have been in the younger ages while those moving out have generally been older.

In Michigan, as in all other areas of the United States, there has been a very noticeable and steady decrease in recent years in the number of births. Presently, there are less than 150,000 per year compared with a high of 208,000 in 1957. Each group of 1,000 women must have 2,110 babies in order to reproduce itself (an average of 2.11 per woman). Should this actually happen, our population would ultimately become stable with births equal to deaths. As recently as ten years ago, women on the average had more than three babies. Currently they have less than two and the figure is continuing to decline. The decrease in births has been particularly pronounced among women in their early twenties. The assumption has therefore been expressed by some demographers that this merely reflects a postponement and will shortly lead to an upsurge in births. We believe that this will prove to be erroneous. In fact, a further decrease in the number of births is a distinct possibility.

Unwanted Pregnancies Reduced

The ready availability to all Michigan residents of a wide range of family planning services has undoubtedly reduced the number of unwanted pregnancies and been an important factor in the recent decrease in average family size. However, the prime factor has been the desire for smaller families by men and women of all racial, ethnic and religious backgrounds. This is believed to reflect changing cultural, social, and economic conditions.

Since many women with unwanted pregnancies receive inadequate or improper care and have a relatively high frequency of complications, the trend toward planned families has been a direct factor in the appreciable reduction noted in the number of stillbirths and infant deaths. Rates for both were at a record low level in 1972 (11.9 and 18.4 per 1,000). Although data are not readily available, this fact has probably contributed also to a decrease in the number of children born with defects such as blindness, cerebral palsy, epilepsy and mental retardation.

It generally has been assumed that the transition from rapid population growth to the anticipated balance between births and deaths would be quite gradual. Michigan, it was thought, would not attain complete population stability (popularly referred to as zero population growth or ZPG) until about the year 2037. If present trends continue as anticipated, the number of births will decrease, the number of deaths will increase, and this balance would be reached much more rapidly, possibly within 15 years. At that point, there would be about 9.8 million Michigan residents.

Median Age Decreases

Because of the large excess of births over deaths, the migration to Michigan of many young people in search of employment and the movement out of retirement age residents, the state has had a

The author is assistant director for research and analysis, Office of Health and Medical Affairs, Michigan Department of Management and Budget.

relatively young population with proportionally few older residents. In fact, the median age of residents decreased two years between 1960 and 1970, from 28.3 to 26.3. The per cent of all residents 65 years of age or older increased slightly, from 8.2 in 1960 to 8.5 in 1970.

Presently, we are in the midst of a reversal of this trend. Primarily due to limited job opportunities, migration into the state is now minimal and is probably exceeded by the number moving out. Our population is increasing about 65,000 per year, or approximately 0.7 per cent, the average age of residents is now beginning to increase and the number of older residents is rising about 25,000 per year. At the end of the present decade, by 1980, there will be about 9.5 million people living in Michigan. This will reflect an increase of 625,000 since the 1970 census, or 40 per cent less than the 1,052,000 in the previous decade. The average age of state residents will probably have risen back to the 28.3 years noted in 1960 and the number 65 years of age or older will be about one million, or 10.5 per cent of the total population.

Metropolitan Growth

Almost all of Michigan's population increase has been in the Detroit metropolitan area, beyond the city's boundaries. A majority of the state's residents now live in suburban areas, primarily the three counties (Macomb, Oakland and Wayne) surrounding Detroit. Concurrently, the major central cities (Detroit, Flint, Grand Rapids and Lansing) as well as the rural counties have been losing residents due to out-migration to suburban areas and other states. Of Michigan's 83 counties, 13, including 12 of the 15 Upper Peninsula counties, lost population between 1960 and 1970. This trend can be expected to accelerate in the present decade. The proportion living in suburban areas should reach 60 per cent by 1980 and may reach 75 per cent by the year 2000.

These emerging trends have widespread, pronounced implications. The following are the most prominent:

1. CHILDREN AND ADOLESCENTS: The decrease in the number of elementary school age children which has already been noted will become more pronounced. A substantial decline in the number of high school age students will begin to occur shortly to be followed before the end of the present decade by those of college age.

The need for new classroom buildings at all levels should therefore be limited for some time. Construction will be concentrated primarily in facilities for new residential areas, replacement of obsolete units and technical school buildings. Unless classroom size is reduced appreciably or an increasing proportion of students complete high school and enter college, the presently prevailing substantial unemployment among school teachers and college faculty will become even more widespread. Among health professionals, a shift from specialties such as obstetrics and pediatrics must be anticipated. Cases of communicable diseases such as measles and mumps which occur primarily in the younger ages should greatly decrease in number. In 1967, 208 Michigan hospitals had 3,911 beds for obstetrics patients. Although this number has now been reduced to 173 hospitals with 3,183 beds, most units have an occupancy rate of less than 60 per cent. A further consolidation will therefore undoubtedly occur. A similar trend can be anticipated in pediatrics units.

2. OLDER RESIDENTS: With an increasing number and proportion of residents in the older ages, a concomitant increase in the prevalence of chronic conditions such as arteriosclerosis, arthritis, diabetes, heart disease, renal disease and stroke must be anticipated. The annual number of deaths has already begun to rise (from 76,855 in 1968 to 79,210 in 1972) and may exceed 90,000 by 1980. Almost all of this rise has been accounted for by heart disease and cancer. These two disease are now the underlying cause of 39 and 18 per cent, respectively, of all deaths. Other major chronic causes are responsible for an additional 16 per cent of all deaths, while 9 per cent died from violent causes (accidents, suicide and homicides). Communicable diseases such as tuberculosis, which at one time were among the leading causes of mortality, now account for less than one per cent of all deaths. The total death rate is currently 8.7 per 1,000.

Unless there is a major breakthrough in the prevention, early diagnosis and/or treatment of heart disease and cancer, the number of deaths

(Continued on Page 346)

*Urethritis, cervicitis, proctitis when due to susceptible strains of *N. gonorrhoeae*

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Trobicin—The advantage of injectable therapy.
Once Trobicin is injected, treatment is usually complete; there can be no problems with patients sharing, skimping, skipping or forgetting medication.

Trobicin—The aspect of privacy.
There are no prescriptions to fill, no capsules to take. Neither family, friends nor co-workers need know or suspect the patient's problem.

Trobicin—Indication and dosage.
Spectinomycin is indicated only for use in acute urethritis and proctitis in the male and acute cervicitis and/or proctitis in the female when due to susceptible strains of *N. gonorrhoeae*. The usual dosage for Trobicin in adult males is 2 grams intramuscularly†; 4 grams intramuscularly in females.

Trobicin—Not effective for syphilis.
Trobicin is not effective for any stage of syphilis. Trobicin may mask or delay the symptoms of incubating syphilis. If concurrent syphilis is suspected, follow the patient serologically for at least 3 months. Patients with syphilis should receive adequate specific anti-syphilitic therapy with an appropriate antibiotic.
Trobicin is contraindicated in patients previously found hypersensitive to it.

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g/ml). Definitive *in vitro* studies have
cross resistance of *N. gonorrhoeae*
pectinomycin and penicillin.

ons: Acute gonorrheal urethritis
tis in the male and acute gonorrheal
nd proctitis in the female when due
ble strains of *N. gonorrhoeae*.

ndications: Contraindicated in pa-
iously found hypersensitive to spec-

gs: Not indicated for the treatment of
ntibiotics used to treat gonorrhea
or delay the symptoms of incubating
atients should be carefully examined
ly serological follow-up for at least
should be instituted if the diagnosis of syphilis is suspected.
Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions should be observed with atopic individuals.
Clinical effectiveness should be monitored to detect evidence of development of resistance by *N. gonorrhoeae*.

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single- and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25° C and use within 24 hours after reconstitution with diluent.

Male—Inject 5 ml intramuscularly for a 2 gram dose. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.
Female—Inject 10 ml intramuscularly for a 4 gram dose.

How supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of 400 mg spectinomycin per ml (as the hydrochloride). For intramuscular use only.
Susceptibility Powder—for testing *in vitro* susceptibility of *N. gonorrhoeae*.
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atients with gonorrheal proctitis and for patients in geographic areas where antibiotic
nce is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly

Michigan Communities Welcome Medical Students for 1974 Summer Program

Eighty-four medical students will be spending the summer in educational programs throughout Michigan this year in a project coordinated by MSMS for the fifth time.

The program, the Student American Medical Association Project for Medical Education and Community Orientation, provides students with the opportunity to observe community health care services under direction of practicing physicians. Students are based in hospitals which have continued financial support of the program despite rising economic pressures. In some cases, county medical societies and individual physicians also contribute financially.

The MECO program was started in Wisconsin in 1969 as a pilot effort aimed at encouraging young physicians' interest in medical practice in rural communities and this year is operating in 35 states. Interest in providing students with community programs in addition to academic studies also has been growing at medical schools. Last year the three Michigan medical schools started the Cooperative Michigan Primary Care Preceptorship Program with the aid of federal funding. Last year 282 students spent periods of a month and longer with physician preceptors in Michigan communities in this program. Assignments for this year now are being completed.

Following is a list of 1974 MECO programs, along with physician program directors and participating students, listed by school and home town.

Town and Hospital	Phys. Prog. Dir.	Student
ALBION Community	Ralph A. Cram, MD	Janet Fairley (U-M), *Albion*
ALLEGAN General	H. E. Schneiter, MD	Vanessa Schweitzer (U-M), *Ann Arbor*
ALPENA General	F. C. O'Dell, MD	Harry Burnett III (WSU), *Detroit*
BATTLE CREEK, Community	Alfred Hamady, MD	Karen Hendricks (Yale), *New York City* Diane Nahri (WSU), *St. Clair Shores* Kathleen Trivich (WSU), *Detroit*
BATTLE CREEK, Leila Y. Post Montgomery	John G. Girardot, MD	Alfred Guerrero (U-M), *Wayne* Bernard Nowacki (WSU), *Livonia*
BAY CITY, Mercy and General (Bay Medical Center)	Paul W. Rowe, MD	Hetty Waskin (U-M), *Brighton* Catherine Clayton (U-M), *Troy* Dawson Lim (U-M), *Detroit* Frederick Holland (U-M), *Flint* Jean Holland (U-M), *Grand Blanc*
DETROIT, Alexander Blain	Alexander Blain, III, MD	Susan Steigerwalt (U-M), *Ann Arbor* Kerry Rifkin (WSU), *Livonia*
DETROIT, Lafayette Clinic	C. E. Schorer, MD	Kenneth Louis (WSU), *Grosse Pte. Shores* Aaron Gordon, Jr. (WSU), *Detroit*
EATON RAPIDS Community	Herman VanArk, MD	Steven Koenigsknecht (U-M), *Lansing*
FLINT, McLaren General	Nancy E. Furstenberg, MD	Maynard Hansen (MSU), *Eaton Rapids* Gregory Brown (U-M), *Flushing* Joe Fedorchik (U-M), *East Lansing* Gary Krosin (U-M), *St. Clair Shores* Grace Elta (U-M), *Davison*

Town and Hospital	Phys. Prog. Dir.	Student
FLINT, McLaren General (cont.)		Donald Blum (U-M), *Flint* William Mestrezat (WSU), *Grand Blanc* Patricia James (U-M), *Detroit* David Mantik (U-M), *Flint*
FRANKFORT, Paul Oliver Memorial	G. W. Willoughby, MD	Dennis Lake (WSU), *Detroit*
FREMONT, Gerber Memorial	Robert E. Paxton, MD	Mark Cichowski (MSU), *Saginaw*
GAYLORD, Otsego County Memorial	W. C. Trowbridge, MD	William Gould (WSU), *Grayling*
GOODRICH, Wheelock Memorial	D. S. Rao, MD	Michael Florentine (U-M), *Clarkston*
GRAYLING, Mercy	Donald D. Burkley, MD	Charles Gosling (U-M), *Kalkaska*
GREENVILLE, United Memorial	Glenn W. House, MD	Lee Stuart (MSU), *Portland*
GROSSE PTE. FARMS, Cottage	John H. Williams, MD	Brad Barker (WSU), *Grosse Pte. Farms* John Schurz (U-M), *Harper Woods*
HASTINGS, Pennock	Charles E. Morrill, MD	Rick Scatterday (MSU), *Plainwell*
HILLSDALE Community Health Center	Clark B. Smith, MD	Robert DePompolo (WSU), *Southgate* Richard Horbal (WSU) *Allen Park*
HOLLAND City	Bernard Meeuwsen, MD	David Verdier (U-M), *E. Grand Rapids* John Arendshorst (WSU), *Holland* Donald Scholten (WSU), *Allendale*
IRON MOUNTAIN, Dickinson County Memorial	Robert L. Anderson, MD	Michael Conley (U-M), *Northville*
LAKEVIEW, Kelsey Memorial	W. B. Bennett, MD	Roger Shore (U-M), *Big Rapids*
MANISTEE, West Shore	Roman R. Knoblich, MD	Jeffrey Geyer (WSU), *Detroit*
MANISTIQUE, Schoolcraft Memorial	L. J. Sell, MD	Ann Marusich (U-M), *Crystal Falls*
MARLETTE Community	R. J. Winfield, MD	James Weeks, Jr. (U-M), *Kalamazoo*
MARQUETTE General	J. Michael Coyne, MD	Andrew White (U-M), *Marquette* Randall Johnson (U-M), *Marquette*

(Continued)

Between them, MECO and the preceptorship program are making it possible for almost every medical student to observe community medical practice at some point during his or her years in medical school. In addition, the schools are offering off-campus clerkships as part of their regular academic programs.

Since its inception in Michigan, the SAMA-MECO program has provided summer educational opportunities for almost 350 medical students. Many of the physicians who supervise students in MECO also serve as preceptors in the medical school-based program.

MSMS offers assistance to the Michigan SAMA chapters as a project of its Education Liaison Committee. The Michigan Hospital Association and the Michigan Academy of Family Physicians cooperate in the program.

Forty-four hospitals are participating in the MECO program this year. In many communities, component medical societies are offering special hospitality to students visiting for summer programs. Randall William Holden, a fourth year student at the Wayne State University School of Medicine, is student coordinator for the Michigan program.

Forty-one of the students are from the University of Michigan Medical School; 29, from the Wayne State University School of Medicine, and 11, from the Michigan State University College of Human Medicine. Three attend medical school outside of Michigan. Sixty-five have completed one year of medical school and 18, two or more years. One student will begin medical studies in the fall.

Town and Hospital	Phys. Prog. Dir.	Student
MT. CLEMENS, St. Joseph	Alberto Cohen, MD	Richard Stone (WSU), *Mt. Clemens* Thomas Kovaleski (WSU), *Mt. Clemens*
MUSKEGON, Hackley	I. J. Kleaveland, MD	Kathleen Lemmen (U-M), *Muskegon* Karen Seaver (U-M), *Muskegon* Robert Dauser (U-M), *Muskegon* Mark Swedenburg *(WSU), N Muskegon*
MUSKEGON, Mercy	J. C. Farmer, MD	David Detrisac (U-M), *Lathrup Village* Wayne Brenneman (University of Cincinnati), *Oxford, O.*
NILES, Pawating	John Doolittle, MD	Stanley Newhall (U-M), *Ann Arbor* Thomas Beach (U-M), *Saginaw*
PETOSKEY, Little Traverse	H. M. Hilal, MD	Arlene Marcy (WSU), *Detroit* James Reus (U-M), *Boyne City*
PETOSKEY, Lockwood-MacDonald		Ellen Arvilla (MSU), *Charlevoix* Erin Arvilla (MSU), *Charlevoix*
PLAINWELL, Pipp Community	Van O. Keeler, MD	Kenneth Berneis (U-M), *Kalamazoo*
PONTIAC General	Robert T. Lyons, MD	Jerome Lentini (WSU), *Cheboygan* Stuart Baine (WSU), *Kew Gardens, N Y.* George Gaudzels (U-M), *Grand Rapids* Brenda Sanford (U-M), *Bloomfield Hills*
PORT HURON Hospital	Anthony C. Gholz, MD K. W. Yost, MD, Associate Director	John Armstrong (MSU), *Grosse Pte.*
ST. JOHNS, Clinton Memorial	James M. Grost, MD	Michael Grossberg (U-M), *Grand Rapids*
ST. JOSEPH, Memorial	Gerald Beal, MD	Margaret Edwards (WSU), *Ann Arbor* Robert Zick (U-M), *St. Joseph*
SALINE Community	Gerald Stair, MD	Leonard Worden (U-M), *Kalamazoo*
	Musad Khan, MD	Christine Litwin (WSU), *West Bloomfield*

(Continued on Page 340)

Medical Students Choose Best Physician Teachers

Six practicing physicians who help train students from Michigan State University's College of Human Medicine in community hospitals in Alma, Flint, Grand Rapids, Saginaw and Lansing have been honored for their "dedication, interest and ability in the art of teaching."

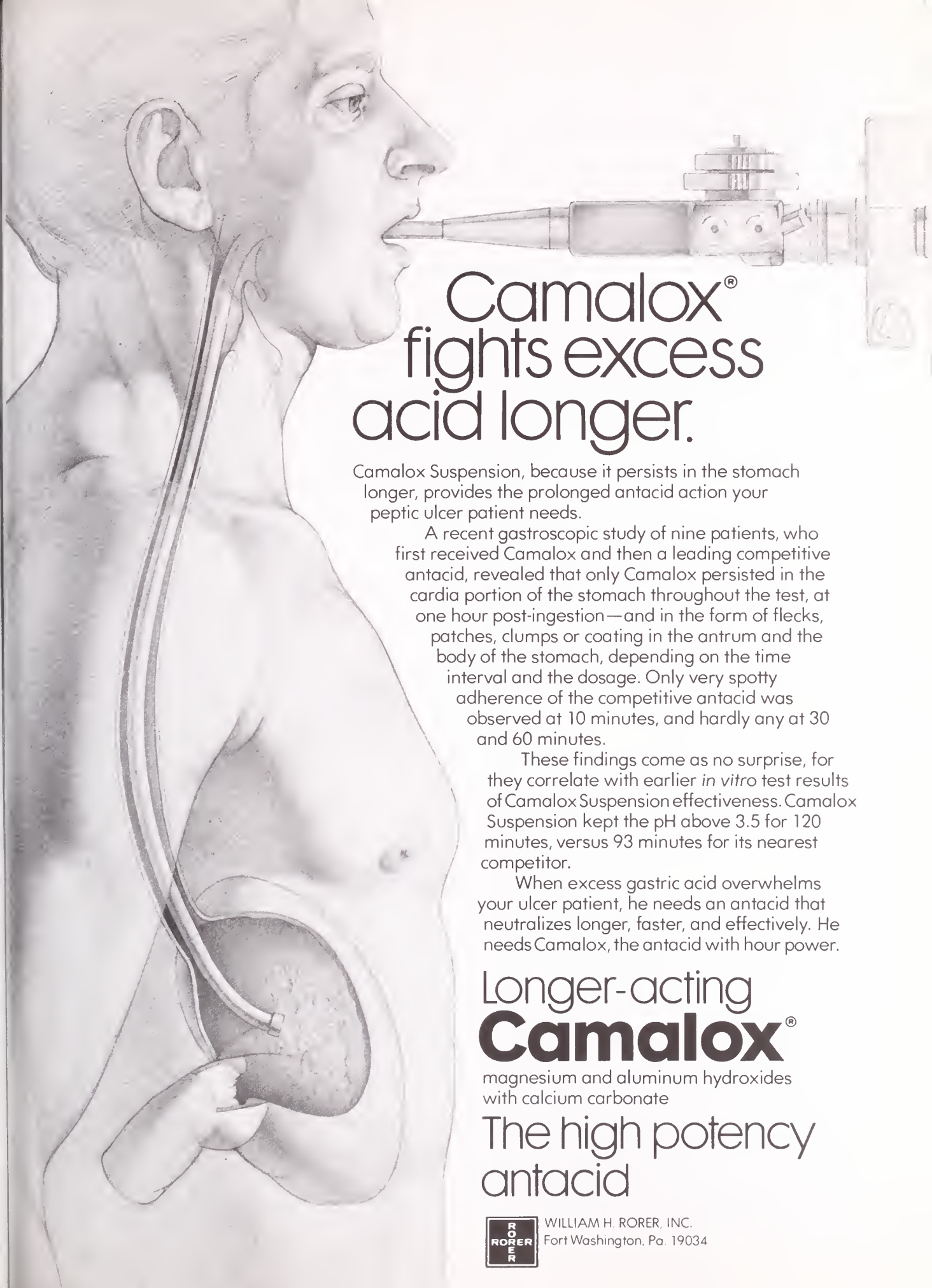
Certificates of achievement for outstanding teaching were awarded March 9 at a commencement convocation held for the 55 MDs graduating from MSU during the current academic year.

Faculty awards went to:

William G. Bouman, MD, Grand Rapids, assistant clinical professor of medicine; Nancy E. Furstenberg, MD, Flint, associate professor of medicine; Charles E. Mueller, MD, Saginaw, assistant clinical professor of medicine; William G. O'Driscoll, MD, Grand Rapids, associate clinical professor of medicine; Bernard H. Smookler, MD, Lansing, associate clinical professor of medicine, and Keith L. Stackhouse, MD, Alma, assistant professor of surgery.

On-campus teaching excellence was recognized with award of a certificate of achievement to Daniel F. Cowan, MD, former associate professor of pathology at MSU and now chairman of the department of pathology at Eastern Virginia Medical School.

All award winners were selected by MSU medical students, who receive part of their undergraduate training in 20 community hospitals in nine Michigan communities.



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Camalox Suspension, because it persists in the stomach longer, provides the prolonged antacid action your peptic ulcer patient needs.

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These findings come as no surprise, for they correlate with earlier *in vitro* test results of Camalox Suspension effectiveness. Camalox Suspension kept the pH above 3.5 for 120 minutes, versus 93 minutes for its nearest competitor.

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Randall William Holden (center), Michigan student coordinator for the Student American Medical Association Project for Medical Education and Community Orientation, observes as Eli A. Coats, MD, of Holland, examines a patient. Holden, who expects to graduate from the Wayne State University School of Medicine in December, was a MECO participant in 1972 at Chippewa County War Memorial Hospital in Sault Ste. Marie and has completed two preceptorships, in the medical schools' cooperative program, with Doctor Coats.

Town and Hospital	Phys. Prog. Dir.	Student
SAULT STE. MARIE, Chippewa County War Memorial	D. D. Finlayson, MD	Carolyn McDonald (WSU), *Jackson* Jim Hays (U-M), *Lansing*
SOUTH HAVEN Community	Joseph Cooper, MD	Joseph Mejia (MSU), *Ionia* Michael Shawbitz (MSU), *Ironwood*
SOUTHFIELD, Providence	Joseph A. Rinaldo, MD John Pfeifer, MD	Robert Scott (WSU), *Columbus, O.* Lawrence Pawl (WSU), *Grand Rapids* Jonathan Jui (WSU), *Grand Rapids*
TRAVERSE CITY State Hospital	Paul E. Kauffman, PhD	Richard Sturm (MSU), *Ann Arbor*
VICKSBURG, Franklin Community	L. E. Appell, MD	Roy Neff (Universidad Autonoma de Guadalajara, Mexico), *Flint*
WEST BRANCH, Tolfree Memorial	Howard Van Oosten, MD	John Ammond (WSU), *West Branch* Chris Schaiberger (MSU), *West Branch*

MDPAC Offers Political Voice

The physician's voice in political affairs is being heard more and more frequently today. The Michigan Doctors Political Action Committee offers Michigan physicians the opportunity for a unified voice to speak to issues that not only will affect their own professional activities but the quality of life for the whole community.

MDPAC supports candidates for public office based on their philosophy, their degree of local physician support and, if incumbents, their previous records.

Michigan physicians may contact any MDPAC board member to express preferences on candidates and to request information about MDPAC membership.

Following is a list of board members:

District

1 Joshua S. Williams, MD, Detroit
2 Sheldon F. Markel, MD, Ann Arbor
3 Thomas R. Berglund, MD, Portage
4 Aaron K. Warren, MD, Cassopolis
5 Perry W. Greene, Jr., MD, Grand Rapids
6 Thomas C. Payne, MD, Lansing
7 James J. Gibbons, MD, Flint
8 Robert Jardinico, MD, Saginaw
9 F. James Stubbart, MD, Muskegon
10 Jack M. Stack, MD, Alma
11 Daniel S. Mazzuchi, MD, Marquette
12 Thomas J. Setter, MD, Mt. Clemens
13 Lee B. Stevenson, MD, Detroit
14 Frank B. Walker, II, MD, Grosse Pointe Park
15 Louis R. Zako, MD, Dearborn Heights
16 Frederick W. Engstrom, MD, Dearborn
17 Robert D. Allaben, MD, Farmington
18 John H. McLaughlin, MD, Birmingham
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Grace C. Appell, Vicksburg
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Brooker L. Masters, MD, Fremont

MSMS Council

Robert C. Prophater, MD, Bay City
Donato F. Sarapo, MD, Adrian

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Doctor Zako serves as MDPAC chairman for 1974 and Doctor Berglund as secretary-treasurer.

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Empirin Compound with Codeine **No. 3**, codeine phosphate* 32.4 mg. (gr. ½); **No. 4**, codeine phosphate* 64.8 mg. (gr. 1). *Warning—may be habit-forming. Each tablet also contains: aspirin gr. 3½, phenacetin gr. 2½, caffeine gr. ½.

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#3, codeine phosphate* (32.4 mg.) gr. ½
#4, codeine phosphate* (64.8 mg.) gr. 1

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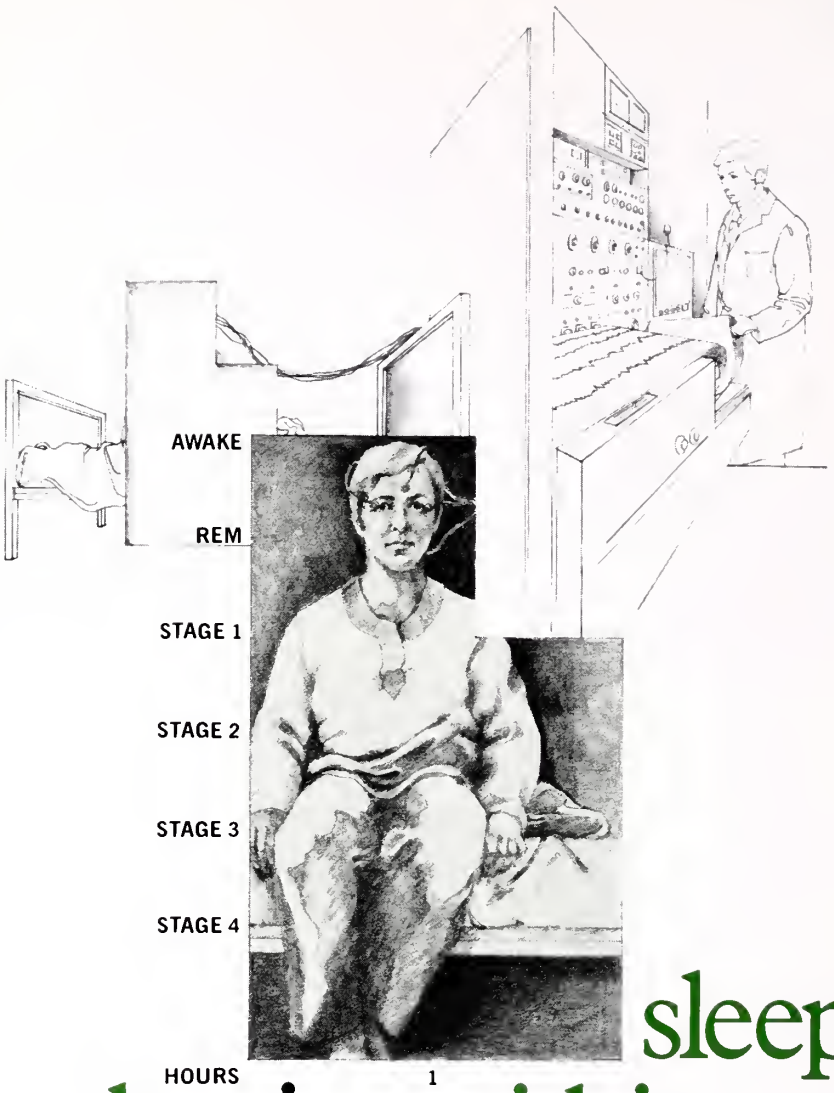

sleep begins within 17 minutes, on average ...

an initial benefit of

Dalmane®

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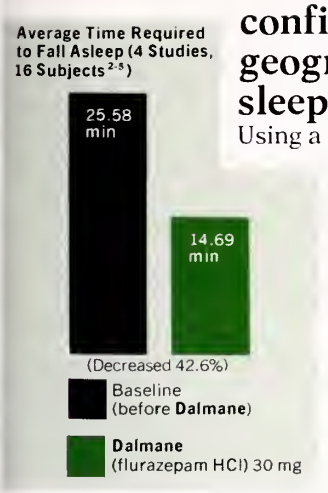
proved by a 22-night clinical study of insomnia patients in the sleep research laboratory and at home[1]

Three insomnia patients selected for difficulty falling asleep were administered Dalmane (flurazepam HCl) 30 mg for 14 consecutive nights. Placebo was given for four nights prior to and four nights after Dalmane. Physiologic tracings on Dalmane nights 1-3 showed sleep induction time averaged 13.90 minutes; on Dalmane nights 12-14, 18.80 minutes. Combined average for the 6 monitored drug nights was 16.35 minutes.[1]


Average Time Required to Fall Asleep (4 Studies, 16 Subjects[2-5])
25.58 min
14.69 min
(Decreased 42.6%)
Baseline (before Dalmane)
Dalmane (flurazepam HCl) 30 mg

confirmed by clinical studies in four geographically separated sleep research laboratories [2-5]

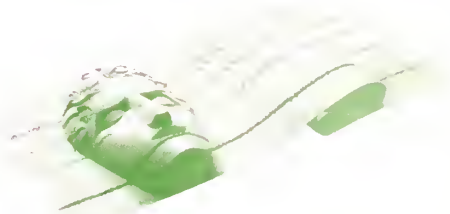
Using a 14-night protocol involving eight insomniac and eight normal subjects, four studies confirmed the sleep-inducing effectiveness of Dalmane (flurazepam HCl) and the reproducibility of this response. On average, one 30-mg capsule induced sleep within 17 minutes. In all these studies, Dalmane induced sleep rapidly, reduced nighttime awakenings, and provided 7 to 8 hours of sleep without repeating dosage[2-5]

Dalmane (flurazepam HCl) induces and maintains sleep, with relative safety

Dalmane is generally well tolerated; morning "hang-over" has been relatively infrequent. While dizziness, drowsiness, lightheadedness and the like have been noted most often, particularly in the elderly and debilitated, physicians should be aware of the possibility of more serious reactions, as noted below.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.
Contraindications: Known hypersensitivity to flurazepam HCl.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.
Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.
Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.
Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.
Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



when restful sleep is indicated

Dalmane®
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One 30-mg capsule *h.s.* — usual adult dosage (15 mg may suffice in some patients).
One 15-mg capsule *h.s.* — initial dosage for elderly or debilitated patients.

- **induces sleep within 17 minutes, on average**
- **reduces nighttime awakenings**
- **sustains sleep 7 to 8 hours, on average, without repeating dosage**

REFERENCES: 1. Kales A, *et al*: *Arch Gen Psychiatry 23*:226-232, Sep 1970
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4. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
5. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ

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Opinion & Dialogue

Is there a need for a drug compendium?

Government Health Official

Henry E. Simmons, M.D.
Deputy Assistant Secretary for Health
Department of Health, Education and Welfare

A drug compendium of the type I envision would fill a definite need for the practicing physician. Such a compendium would give him all the information necessary for using a drug intelligently, and it would do so in a clear, concise, convenient, objective and balanced fashion.

What a Compendium Should Contain

I believe the compendium should inform the doctor what a drug will do, when he should use it, for what type of patient, for how long, in what dose, what benefits his patient is likely to obtain, the risks involved, and cross-reaction with other drugs.

The information would be based on the package insert and have the same legal status. In fact a complete compendium with complete and current information might even eliminate the necessit

Maker of Medicine

Joseph F. Sadusk, Jr., M.D.
Warner-Lambert Company

A drug compendium, or preferably compendia, should, I believe, be private, not federal, in sponsorship. They should contain comprehensive listings of drugs available for prescribing. They should be single, legibly printed volumes of reasonable size, updated quarterly or semiannually and completely revised every yea

Function of a Compendium

A compendium should furnish the following information on drugs in the following order: indications for use, side effects, adverse drug reactions, contraindications, drug interactions, drug dosage ar the dosage forms marketed. Drug prices should not be included because they vary so widely and change rapidly.

No compendium should set forth drugs of choice or discuss relative efficacy. Such questions must be left for the practicing physician to decide, whether on the basis of the medical literature, hi own clinical experience, advice o colleagues, information supplied by manufacturers, and so on.

Nor should a compendium undertake to educate the doctor how to use drugs. Rather, it must be a reference source designed p marily to refresh his memory as t drugs he may not use regularly. I

for a package insert in many instances. This would constitute a substantial saving for the manufacturer.

By a complete compendium, I do not mean a volume of prohibitive size. You don't need a book describing 25,000 products with an enormous amount of repetition. Rather, drugs should be arranged by class. Mutually applicable information would be provided, along with brief discussions pinpointing differences in specific drugs of that class. Listings would be cross-indexed in a useful way.

Other Available Documents as Sources of Information

Existing references such as PDR and the AMA Drug Evaluation are obviously useful but they are incomplete. Either they are not cross-referenced by generic name and do not group drugs with similar characteristics, or they do not list all the available and legally marketed drugs. And some of those omitted may be very useful. On the other hand, drugs made by more than one supplier, tetracycline for example, may be fully described a dozen times in the same book.

While perhaps PDR could be rearranged and cross-indexed with generics included, and while the AMA Drug Evaluation might also be modified and expanded, I am not sure that the end result would have all the attributes required for a useful compendium. At the same time, you would run the risk of amassing a voluminous and unwieldy tome.

Should Editorial Comments Accompany the Listings?

Subjective judgments, in my opinion, have no place in a compendium. However, if there is substantial evidence based on a sound body of science concerning relative efficacy of several drugs, certainly that information should be included. The committee of experts compiling and editing a particular section would also have to assess and indicate instances where a meaningful difference between drugs is pertinent.

Sponsorship, Compilation and Editing

Producing a book like this would undoubtedly be difficult and demanding. It would obviously take a great deal of talent and expertise, and would require a varied and experienced group, ranging from writers and editors to highly skilled clinicians and pharmacologists. Style, format and clarity of language would play an important part in determining the usefulness of the book. And it should be updated periodically and completely revised annually.

I have no opinion whether the government or the private sector should sponsor and/or finance the compendium. What is most important is that the compendium be an authoritative, objective and useful source of information for the doctor to have at hand as a ready reference.

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should in no way imply control over the practitioner's prerogatives.

Why Another Compendium?

A practicable, single-volume compendium cannot, nor is it necessary to, include all drugs on the market today. From my practice of internal medicine for some 15 years, my experience as a consultant, and as a faculty member of four or five medical schools, I would estimate that a doctor uses only 30 to 35 drugs regularly. The 1972 Physicians' Desk Reference, incidentally, contained about 2,500 entries.

As to whether there should be a federal compendium, in my opinion, as stated earlier, the answer is easy—there should *not* be one. The proposal assumes that existing compendia are inadequate. We're not sure of that at all. Whatever its imperfections, the present drug information system in the U.S. is open, multifaceted, pluralistic and extensive. Good compendia exist, as well as other ample sources on drug therapy, ranging from journal literature through AMA Drug Evaluation to company materials. Not all physicians may use such sources as often or as well as they should, but that is the fault of the man, not of the sources.

In any event, rather than produce another book, it makes much more sense to work on improving existing compendia, and perhaps they could, as knowledge advances, include more accumulated clinical data and experience, and more information on drug interactions and adverse reactions.

Implications of a Federal Compendium

Take a hard look at the implications of a federal compendium. It would have the force of law, virtually dictating what drugs to use and how to use them. In effect, it would be a regulatory document with legal or quasi-legal status, posing medical/legal problems similar to those the doctor may now encounter if and when he departs from the provisions of the package insert. A compendium under federal aegis would tend to restrict decisions on drug therapy to one orthodox level—a most dangerous trend for medicine.

New Compendium—A Medical Option

I detect no ground swell of initiative or support whatsoever for a federal compendium—or, for that matter, for a new compendium of any type. A 1969 PMA survey conducted by Opinion Research Corporation found that only 15 per cent of those physicians interviewed felt a new compendium was needed. And a large majority did not favor the involvement of the federal government if one were to be created, preferring instead a nongovernmental consortium.

Even if we come to a time when the medical profession itself opts for a new kind of compendium, it should be handled and financed, ideally, outside both government and industry. Final review and editorial authority could be delegated, say, to specialty bodies and medical societies—but above all, *not* the government.

Surely the health care system in the United States has far more vital matters to consider than the extensive cost and effort that would have to go into the preparation and maintenance of a new, monolithic compendium, and especially one bearing the imprimatur of the federal government.

Opinion & Dialogue

What is your opinion, doctor? We would welcome your comments.

The Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

from these two causes will increase sharply in future years. Because of the rising number and proportion of older state residents, the death rate will approach 10 per 1,000 by 1980 and may be in excess of 12 by the end of the century. Cancer mortality is probably most amenable to some reduction. Deaths from many cancer sites have declined in recent years due to earlier detection as well as new and improved treatment procedures. Most of the continuing increase has been accounted for by an average annual rise of more than 100 lung cancer deaths. Lung cancer now accounts for 20.8 per cent of all cancer deaths compared with 18.6 per cent four years earlier. Further continuing preventive efforts (i.e., reduce cigarette smoking and minimize industrial and other air pollution) would therefore be particularly meaningful. However, even if all cancer mortality were eliminated, average life expectancy would increase less than five years and would barely exceed the three score and ten cited in the Bible.

The increasing number of older residents will require new and expanded social and health related resources and services. The ratio of population in the working ages (18-64) to that in the retirement ages (65 and over) will decrease and it will therefore become increasingly difficult to find the funds and resources required for these services. A review of the state's role and responsibility in meeting these needs would appear to be indicated. The construction of a variety of facilities to serve this population segment can be expected to continue for some time, quite possibly at an accelerating pace. In view of the large number of one person households in this age group, home care and other social services will probably have to be expanded. Due to higher male mortality rates at every age level, the current excess of females in the older ages will become even more pronounced. The implications of the widening sex ratio require careful consideration. A shift in medicine and related professions toward specialties such as gerontology, cardiology, gynecology and psychiatry should be fostered. The need for such health manpower and services will be most acute in rural counties and in the central areas of major cities where the increase in the number of older residents will continue to be most pronounced.

3. URBAN CENTERS AND RURAL AREAS: Detroit, in particular, is faced with a continuing loss in the number of its residents and is increasingly populated by the old, the poor, the sick, the community dependent and the recent inmigrant from other depressed areas within and without the state. However, the state's other major cities as well as the rural areas face similar problems.

Available data clearly reflect this trend. Detroit's population currently is decreasing an estimated 15,000 persons per year due to migration of young, middle class residents to the suburbs beyond its boundaries. In 1970, the city had 1.5 million residents, or 17.8 per cent of the state total. By 1980, this figure is anticipated to be less than 1.4 million, or 14.7 per cent of the total. The average age in Detroit is three years older than for the rest of the state, the death rate is 28 per cent higher and life expectancy is four years less. Detroit's residents presently acount for 24 per cent of all Michigan deaths, 61.1 per cent of all homicides, 23.6 per cent of all infant deaths, 46.9 per cent of maternal deaths, 46.7 per cent of venereal disease cases, 42.2 per cent of tuberculosis cases, 41.5 per cent of those receiving Aid to Dependent Children and 39.5 per cent of all Medicaid eligibles. Concurrently, the city's tax base is shrinking and an average of one new residential block per week exhibits initial signs of deterioration.

Lake County, northeast of Muskegon, offers an extreme example of rural poverty. Its 5,700 inhabitants have an average family income of $6,000, 48.5 per cent less than the comparable statewide figure. The age adjusted mortality rate is 16.7 per cent higher while life expectancy is 3 years lower than for the entire state. Lake County ranks near the bottom among Michigan's 83 counties in all socio-economic and health related indices. There are presently no resident physicians, dentists or optometrists. A federally funded comprehensive health center is scheduled to cease operations in November, 1974, with no anticipated replacement.

If present trends continue, these figures will increase further. Detroit, and to a lesser extent the other cities as well as the rural counties, will face a growing gap between available resources and needs which can only be bridged by outside support, cooperative effort and coordinated programs for the provision of social and health related services.

4. NONWHITE RESIDENTS: About two-thirds of Michigan's one million black residents live in Detroit with many of the rest concentrated in the state's other major urban centers. A majority of the small number, (less than 50,000) of Indians and other nonwhites in Michigan also now live in Detroit. The rapid increase which occurred in earlier years has now slowed perceptably with the decrease in migrants from other states. Despite a drop in the number of births to all racial groups, black fertility rates remain about one-third higher than comparable white figures. However, less well publicized and recognized is the fact that black death rates, when adjusted for the differences in age distribution of the two races, are also considerably higher. The natural increase (births minus deaths) is therefore quite similar among Michigan's black and white residents. Thus the proportion of Michigan residents who are black (11.2 per cent) will probably not change significantly.

Life expectancy among black males and females is about six years less than among their white counterparts (65 versus 71 years) and the gap is widening. Undoubtedly, socio-economic differences as well as the concentration of blacks in urban core areas with an increasing deficit of health resources are related to this trend. Black male life expectancy in Michigan actually decreased 1½ years in the past decade. In part, this is due to the rapidly increasing number of young black homicide victims in Detroit. In part, also, it is probably related to the increasing employment of black males in professions and industries with hazardous health conditions.

5. HEALTH MANPOWER: For most health professions, statewide ratios of available manpower to population are adequate and can in fact be expected to improve further in coming years. However, there is a high and increasing concentration of such professionals in suburban areas near major cities. Conversely, manpower resources are limited in rural counties and urban centers.

Michigan now has 12,200 physicians (10,200 medical doctors and 2,000 doctors of osteopathy) engaged in patient care, a ratio of one per 750 residents and close to the national average. Oakland County, in Detroit's suburbs, has one physician for every 490 inhabitants while conversely in the largely rural Upper Peninsula counties this ratio is one per 1,570. Of Michigan's 83 counties, 12 had more than 2,500 residents for every physician in private practice. Comparable variations exist for most other health professions.

When current expansion programs are completed, Michigan's four medical schools will graduate 700 physicians per year. With an estimated 300 retiring or dying annually and with in and out-migration virtually in balance, the number of physicians engaged in patient care in the state should reach 15,000 by 1980 or a ratio of one per 633. However, since many physicians in rural counties or inner city areas are near retirement age with few replacements, the presently existing maldistribution will probably widen.

Given these facts, the continuing lack of coordinated action can surely no longer be justified. The formulation and implementation of a comprehensive health plan as well as a population policy for Michigan would appear to warrant high priority. This might include a review of the implications of the impending population stability and of the growing division between rural areas, the major cities and their suburbs. A determination of priorities regarding the training and utilization of health manpower in relationship to needs required and available resources, appropriate regulation and other action, as well as relative (public versus private) responsibility within this context is indicated.

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DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpuberal cryptorchidism with evidence of hypogonedism. Cholestetic hepatitis with jaundice and altered liver function tests, such as increased BSP retention and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the **male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **HOW SUPPLIED:** 5, 10, 25 mg in bottles of 60, 250.

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MEETINGS

June 8-9—Symposium in clinical neurotology, "Treatment of the Dizzy Patient," sponsored by Michigan State University College of Human Medicine at Kellogg Center, East Lansing, contact: Bruce Alderman, Kellogg Center, MSU, East Lansing, Mich. 48824.

June 12—MSMS Council, MSMS Headquarters, contact: Warren F. Tryloff.

June 14—Second Annual Neuromuscular Disease Symposium sponsored by the Michigan State University colleges of human, osteopathic and veterinary medicine and the Muscular Dystrophy Associations of America in cooperation with its Greater Metropolitan Detroit Chapter, at Kellogg Center, East Lansing, contact: Bruce Alderman, Kellogg Center, MSU, East Lansing, Mich. 48824.

June 14—Infection control conference for physicians and other health care professionals sponsored by the Michigan Society for Infection Control, the Michigan Department of Public Health and Mercy Hospital, Grayling, at the Grayling Holiday Inn, contact: Faye A. Luscombe, MPH, 1500 Blakeslee, Kalamazoo, Mich. 49001.

June 19-21—Annual convention of the Michigan Hospital Association, Grand Hotel, Mackinac Island, contact: MHA office, 2213 E. Grand River Ave., Lansing, Mich. 48912.

June 22-27—AMA Annual Meeting, Chicago, contact: AMA, 535 N. Dearborn St., Chicago, Ill. 60610.

June 21-22—Meeting of Upper Peninsula Medical Society, Terrace Garden, Escanaba, contact: James R. Dehlin, MD, 8 S. 11th St., Gladstone, Mich. 49837.

July 6-10—Michigan Academy of Family Physicians Annual Meeting and Scientific Program, Park Place Motor Inn, Traverse City, contact: MAFP office, 933 Wing St., Plymouth, Mich. 48170.

July 12-13—North Central Regional Meeting on "Primary Care in Group Practice" sponsored by the American Association of Medical Clinics at the Merrillville (Ind.) Holiday Inn, contact: L. W. Neal, MD, Hammond Clinic, Munster, Ind. 46321.

July 24-26—Annual Coller-Penberthy-Thirlby Medical Conference, Park Place Motor Inn, Traverse City, contact: Laurence P. Skendzel, MD, Munson Medical Center, Traverse City, Mich. 49684.

July 25-28—Summer meeting of the Michigan Psychiatric Society, Inn on the Park Hotel, Toronto, contact: Charles W. Davenport, MD, University Hospital, Ann Arbor, Mich. 48104.

Aug 1-3—MSMS Council, St. Clair Inn, St. Clair, contact: Warren F. Tryloff.

Sept. 23-27—Family practice review, sponsored by the Michigan Academy of Family Physicians, at Scott Hall, Wayne State University School of Medicine, contact: MAFP office; 933 Wing St., Plymouth, Mich. 48170.

Sept. 25—MSMS Council, MSMS Headquarters, contact: Warren F. Tryloff.

Oct. 1—Annual surgical symposium, "Surgical Disease of the Pediatric Gastrointestinal Tract," sponsored by the Department of Surgery, Children's Hospital of Michigan, and Wayne State University School of Medicine Department of Surgery, at the hospital, contact: Department of Community Relations, Children's Hospital of Michigan, 3901 Beaubien Blvd., Detroit, Mich. 48201.

Oct. 4—Mid-year Meeting, Michigan Hospital Association, Park Place Motor Inn, Traverse City, contact: MHA office, 2213 E. Grand River Ave., Lansing, Mich. 48912.

Oct. 9-10—1974 Annual MSMS Scientific Meeting, Sheraton-Cadillac Hotel, Detroit, contact: Helen Schulte, MSMS Headquarters.

Oct. 11-12—Annual reunion of the University of Michigan Medical Center Alumni Society, Ann Arbor, contact: Robert Richards, Towsley Center, Ann Arbor, Mich. 48104.

Oct. 31-Nov. 2—Course on "Implant Surgery for Joints and Tendons in the Hand," sponsored by the American Society for Surgery of the Hand, at Blodgett Memorial Hospital, Grand Rapids, contact: Alfred B. Swanson, MD, 313 Blodgett Medical Bldg., Grand Rapids, Mich. 49506.

Nov. 6—MSMS Council, MSMS Headquarters, contact: Warren F. Tryloff.

Dec. 11—MSMS Council, MSMS Headquarters, contact: Warren F. Tryloff.

Michigan Medicine each month lists upcoming meetings in Michigan or of special interest to Michigan physicians if out of state. Please submit notices for publication at least two months prior to meeting dates.

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1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

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Welcome

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

Michael Barbarich, MD, St. Francis Hospital, Escanaba 49829
J. Howard Binns, MD, Detroit General Hosp., Detroit 48226
Larry E. Braak, MD, 729 Spruce St., Marquette 49855
James I. Breckenfeld, MD, Oakwood Hospital, Dearborn 48124
James D. Brodeur, MD, 3 Woodland Rd., Houghton 49931
Robert D. Brouwer, MD, 406 Bronson Medical Ctr., Kalamazoo 49006
Daniel D. Chapman, MD, 3349 Tacoma Circle, Ann Arbor 48104
Darapen Chivalak, MD, 17700 W. Warren, Detroit 48228
James Chou, MD, Route #1, Box 9H, Manistique 49854
Stanley W. Coulthard, MD, 3547 Burbank Dr., Ann Arbor 48105
John A. Couzens, MD, Bon Secours Hosp., Grosse Pte. 48230
Melvin S. Dennis, MD, CMU Student Hlth. Ctr., Mt. Pleasant 48858
Thomas W. Fawell, MD, 5890 Ridgebrook, S.E., Grand Rapids 49508
Marvin Fields, MD, 2424 Spring Arbor Rd., Jackson 49203
John C. Fischer, MD, St. Joseph Mercy Hosp., Ann Arbor 48104
Jay K. Harness, MD, 626 Louise St., Ann Arbor 48103
Lawrence S. Hawkins, MD, Family Practice Ctr., Sparrow Hosp., Lansing 48902
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PEOPLE

G. Jan Beekhuis, MD, and Eugene Rontal, MD, of Detroit,

were major participants in the 10th annual meeting of the American Academy of Facial Plastic and Reconstructive Surgery held in April in Palm Beach. The two otolaryngologists were among 50 medical specialists who presented papers and lead discussions on latest advances in head and neck plastic surgery. Doctor Beekhuis served as president of the academy for 1973-74.

Henry Green, MD, of Southfield, and George Ritter, MD, of Lathrup Village,

shared in the grand award in the 15th annual search for new hospital achievements conducted in 1973 by the Michigan Hospital Association and Blue Cross. Doctors Green and Ritter, both cardiologists, were honored for their roles in developing the new mobile emergency care program put into service by Providence Hospital, Southfield, with cooperation of the city of Southfield. Sharing in the award were Evelyn Eusebio, RN, director of inservice nursing at Providence, and Ronald Achilli, administrative assistant at the hospital.

Bernard J. Harris, MD, of Flint,

is the new president of the Flint Academy of Surgery. An orthopedic surgeon, he is on the staffs of St. Joseph, McLaren and Hurley hospitals in Flint. He is a graduate of the University of Michigan Medical School. Doctor Harris is active in the teaching program at the Michigan State University College of Human Medicine Flint Medical Campus.

Paul Lowinger, MD, of Detroit,

was elected national treasurer of the Medical Committee for Human Rights at the committee's annual convention April 20 in Pittsburgh. MCHR was founded in 1964 as a group of health care professionals and consumers working for a national health program. Doctor Lowinger has served on its executive committee for many years and was national chairman from 1969 to 1970. He is adjunct associate professor of psychiatry at Wayne State University, a consultant to Lafayette Clinic and research coordinator of the Detroit Model Neighborhood Drug Abuse Program. Doctor Lowinger also is the author of an article on "Psychosurgery: The Detroit Case" appearing in the April 13 issue of *The New Republic.*

William R. Olsen, MD, of Ann Arbor,

has been elected president of the Michigan Chapter of the American College of Surgeons. Doctor Olsen is professor of surgery at the University of Michigan Medical School and coordinates the school's postgraduate teaching efforts in surgery throughout the state. A native of Frankfort, Doctor Olsen practiced in Traverse City before joining the U-M faculty in 1964.

Jack Ryan, MD, of Warren,

recently was honored for his service as 1973-74 chairman of the Wayne State University School of Medicine Annual Fund. He received a certificate of appreciation from Robert D. Coye, MD, WSU medical dean. Doctor Ryan, who serves as a trustee of the WSU Medical Alumni Association, received his MD degree from Wayne in 1955.

Sidney N. Smock, MD, of Saginaw,

has been appointed director of the University of Michigan Hospital's emergency service. U-M announced that Doctor Smock will supervise a major reorganization of the emergency service, geared to provide quicker, more comprehensive care for unscheduled patients. He also will be involved in expanding the U-M role in training of local ambulance drivers, firemen and other emergency personnel. A 1960 graduate of the U-M Medical School, Doctor Smock formerly was vice president of the St. Mary's Hospital Emergency Room Corporation in Saginaw.

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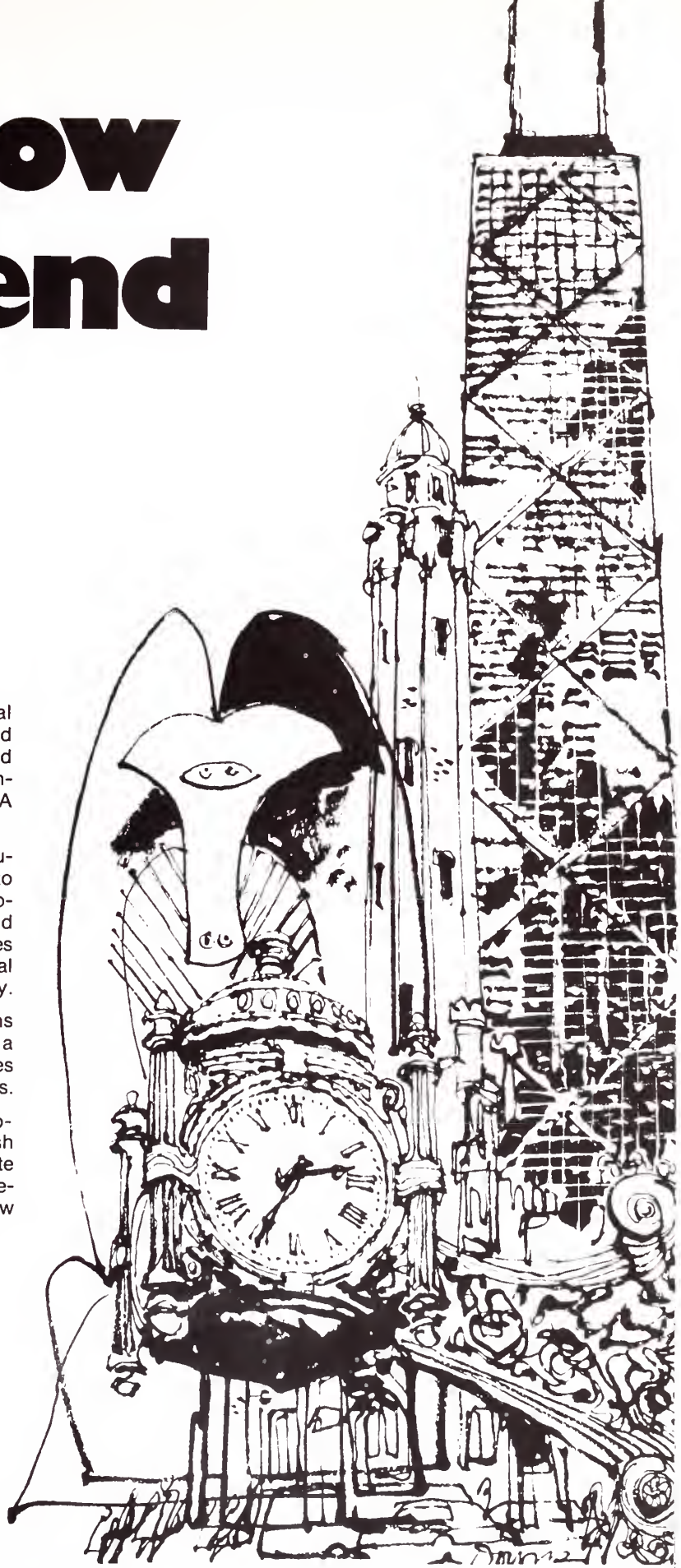

Book Review

New Novel Spins Web of Medicine, Suspense

The Anatomy Lesson, by Marshall Goldberg; G. P. Putnam's Sons, $7.95.

Our physician novelist laureate has done it again. Doctor Goldberg (the director of medical education at Hurley Hospital in Flint) previously wrote the successful novel *The Karamov Equation,* which has been highly regarded and has been optioned for a film production. Unfortunately I must admit I have not as yet read *The Karamov Equation,* I suppose the thought of equation reminds me too greatly of mathematics rather than suspense, however after reading *The Anatomy Lesson,* I intend to.

Anyone who knows Marshall knows he is articulate and expressive and should be able to put words together well. The novel gives an insight also into a vivid imagination and the ability to weave suspense, medicine and human understanding into an interesting and rapidly progressing story.

The story is that of a medical student, Dan Lassiter, and his struggle in his relationship to his anatomy cadaver. Early on, he discovers that his cadaver, a young individual, had a subdural hematoma. From here on Dan Lassiter is involved in a compulsion to find the etiology of the hematoma, a compulsion that almost destroys his medical career before it starts. Enough of the plot, suffice it to say, once started the book must be finished.

For the medical person there are memories of the anatomy laboratory and its frustrations; the fears and second thoughts of medical student days and the questioning philosophies of youth.

As an old Bostonian, I also enjoyed trying to pick out the familiar haunts of my medical school days as Marshall described them.

All in all I found the novel enjoyable and look forward to more novels by the author.

John W. Moses, M D
Scientific Editor

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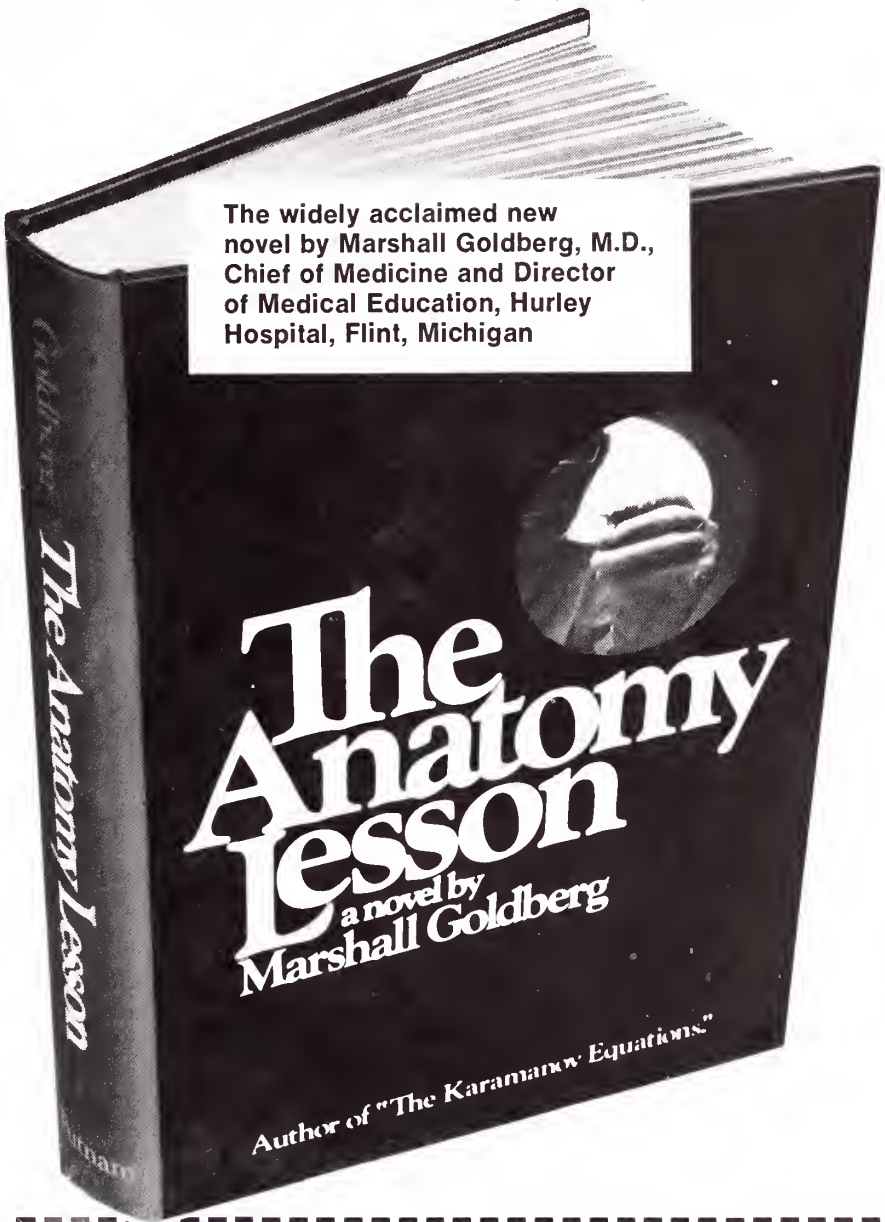
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In Memoriam

Domenico M. Annessa, MD
Detroit

Domenico M. Annessa, MD, 81, a Detroit family physician for more than 50 years, died April 18 in St. Joseph Hospital. Doctor Annessa received his medical education in Italy and attained his Michigan license to practice in 1923. He was on the staff of Doctors' Hospital.

Dennis D. Kovan, MD
Southfield

Dennis D. Kovan, MD, 71, a Southfield pediatrician, died April 16 in Sinai Hospital. Doctor Kovan was an honor graduate of the University of Michigan Medical School in 1924 and served as an army medical corps captain during World War II. He was on the staffs of Sinai and Children's hospitals.

Robert T. Lossman, MD
Traverse City

Robert T. Lossman, MD, 69, a Traverse City pathologist for 35 years, died April 21. Doctor Lossman, a native of Illinois, was graduated from the Loyola University School of Medicine in Chicago and initially came to Michigan for a residency in psychiatry at Traverse City State Hospital.

Becoming interested in pathology, he completed a master's degree program in pathology at the University of Michigan in 1938 and established a clinical laboratory at Munson Medical Center, also serving as director of the laboratory at Traverse City State Hospital. Doctor Lossman completed additional work in clinical pathology at Wayne State University in 1946 and 1947.

A former secretary of the Grand Traverse-Leelanau-Benzie County Medical Society, he was certified by the American Board of Pathology and belonged to the Michigan Society of Pathologists, the College of American Pathologists, the American Society of Clinical Pathologists and the American Association of Blood Banks.

William James Padelford, MD
South Lyon

William James Padelford, MD, of South Lyon, died Feb. 20 at the age of 57. A family physician, Doctor Padelford was graduated from the Wayne State University School of Medicine in 1950. He was a navy veteran.

Sarah S. Schooten, MD
Detroit

Sarah S. Schooten, MD, a Detroit pediatrician for almost 50 years and one of Michigan's most honored physicians, died April 21 at her home. She was 79. Among the awards bestowed on Doctor Schooten for her humanitarian services, carried out on a world wide basis, are the MSMS Certificate of Commendation, the Salvation Army's highest award, its William Booth Founders Award, and Wayne State University School of Medicine's Distinguished Service Award. She was cited in 1970 by the *Detroit News* as one of Detroit's most outstanding women.

Doctor Schooten lived a storybook life. Born to missionary parents in the Far East, Doctor Schooten spent part of her childhood in Chile and, after school years in New Jersey, went to Germany to study medicine. World War I intervened and on her voyage returning to her family in Chile, she met a Dutch sea captain whom she married, only to be widowed three months after the ceremony. It was several years before the young widow was able to resume her medical education at Wayne State University, but she received her MD degree in 1926 and became the first woman intern at Providence Hospital, where she also completed a pediatrics residency.

Doctor Schooten was chief of pediatrics at Booth Memorial Hospital from 1930 to 1958 and also practiced at Crittenton and Highland Park General hospitals, along with Providence. Doctor Schooten served as attending physician for several children's homes and was a willing volunteer with a number of philanthropic agencies. Her private philanthropies included gifts of animals and agricultural supplies to Korean villages along with support of children in Korea, Vietnam and Equador. Four years ago, Doctor Schooten went to Kenya to give life saving measles vaccinations to 12,000 African children.

Charles H. Sharrer, MD
Grosse Pointe Park

Charles H. Sharrer, MD, 72, of Grosse Pointe Park, a Detroit area family physician for 50 years, died April 26 at Deaconess Hospital. A graduate of the Detroit College of Medicine, he was on the staffs of Deaconess, Cottage and Doctors' hospitals.

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Beating the Deadline

By Herbert A. Auer, Executive Editor

BOYNE MOUNTAIN is the dateline for these items about the annual MSMS House of Delegates meeting held there May 5, 6 and 7.

Delegates who wanted to play the fabulous Boyne golf course were disappointed because of rainy, chilly weather. The speaker of the house, **Vernon V. Bass, MD,** opened the session with a ski "weather" report because there were traces of snow left on some of the protected slopes.

At every meeting there's a group that gets together to vocalize — when and if a pianist can be found. **Fred C. Brace, MD,** a delegate from Kent, was found, and he knew all the good ol' standards.

"I remember him," exclaimed **Joseph LaHood, MD,** a Macomb delegate, when he listened to **Raymond Holden, MD,** member of the AMA Board of Trustees, who was a guest at the MSMS House. Doctor Holden, now of Washington, D.C., supervised medical student LaHood when he delivered his first baby.

Andrew Hunt, MD, dean of the MSU College of Human Medicine, participated in the three-day House meeting as a seated delegate for the first time. The MSMS bylaws recently were amended so the deans, if they are MSMS members, are now delegates. The WSU medical dean, **Thomas D. Coye, MD,** also an MSMS member, was not present.

Several delegates asked **Dean Carron, MD,** what medical school he was from. But in his case, Doctor Carron's first name is Dean. He is a psychiatrist in Ann Arbor and a Washtenaw delegate.

Karin Tansek, MSU SAMA president, **Mark Campbell,** WSU SAMA president, and **Bill Middleton,** U-M SAMA president, were the three voting student delegates. The alternates were **Jeanne McKibben,** MSU and **Bill Holden,** WSU. **Bryan Shumaker,** MSU medical student, was there as a *Michigan Medicine* special writer to develop an article "from the student's point of view." It is scheduled in the July journal.

Speaker Bass presides at Annual Session.

When **Doctor Bonzelaar** collected attendance slips at the door of House meetings some delegates were not sure which of the identical Bonzelaar twins he was. The man was Alvin Bonzelaar, MD, a delegate from Ottawa. His twin, Marvin Bonzelaar, MD, practices in Grand Rapids.

James C. Danforth, Jr., MD, Grosse Pointe Woods, chaired a reference committee that met in an unfinished room in the basement of the new Boyne conference building, and the chill index was high. He told delegates "now I know where they store the ice sculpture from the ski season until the next year."

Reference Committee C spent some time talking about football — understandably because one of the committee members was **John P. Papp, MD,** who played some quarterback for the professional Falcons. Doctor Papp, of Grand Rapids, was a delegate for the MSMS Section on Gastroenterology.

Dean Hunt and medical sophomore Tansek represent MSU College of Human Medicine administration and students.

Dr. Holden speaks to delegates.

Before deciding to make Valium (diazepam) part of your treatment plan, check on whether or not the patient is presently taking drugs and, if so, what his response has been. Along with the medical and social history, this information can help you determine initial dosage, the possibility of side effects and the ultimate prospects of success or failure.

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Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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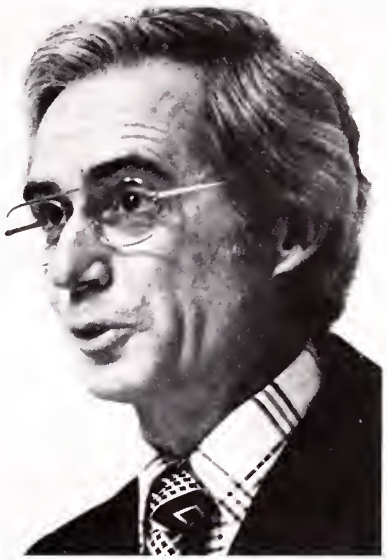
Medicine Can Produce New Leaders

I sense that many who will read these words share my depression about the inferior level of morality extant today, not just in the USA, but worldwide; not just in personal ethics, but in government, business, banking, education, the entire rubric of our society. And it seems the prognosis is equally bleak.

Every generation from the beginning of time has felt this way: "Things are really going to the dogs!" "Things just aren't like they used to be!" But it's different this time.

Communications are so sophisticated that we witness the war in Vietnam on our living room TV; we watch leading government officials perjure themselves; we watch man walk and talk on the moon — at the moment it is happening! And yet mankind goes on as if there really were a new frontier just around the corner.

Man still acts as though war is a viable means of settling an argument. The arms race is still very real. We try to ignore the energy crisis. We act as though there really isn't a worldwide shortage of raw materials. There is worldwide inflation, and a true teeth shattering depression is a real possibility. We turn our back on the Palestinian refugee problem. The Middle East war may never end except as part of a larger conflagration.



Doctor Masters

See what I mean? Mankind has not changed much, fundmentally. But in this era there is a true concept of the finite in future human expansion. It is no longer possible for "business as usual" if there is to be a moral climate conducive to hope, inspiration and all of the beauty that the human personality needs to flower and be productive.

There is still a chance. Never has knowledge and technology been so advanced. All we need is the will and decision to re-order our priorities and get on with the business of living. To do that one main ingredient is needed: leadership.

My real concern is that I do not see the necessary leadership coming forward anywhere in the world. There are no Churchills, De Gaulles, Teddy Roosevelts or Jeffersons coming out of our political framework, from business, from the church, from the universities. All are possible, but hardly likely, sources.

What about Medicine, us, doctor? At first glance our track record is not so great for leadership, either. But what other profession is so intimate with the human equation, the hopes, aspirations, fears, frustrations, ambitions, capabilities, the capacity for joy and achievement, the depressions? Isn't our entire work wrapped around the total human experience? Why shouldn't our dedicated profession be able to develop men and women with insight and the capacity to lead the state, the nation, the world out of this moral swamp we are plunging headlong into? The answer is that it can. (*Gov. Bowen of Indiana may be the forerunner of more to come.*)

It is late, but high time for each county society to nourish its leadership. You all have potential leaders in your groups. I see and talk to them all around the state. Encourage them to come forward; then support them actively, not just in medical politics, but in the community, the state, nationally.

We are all saying that health care is so much more than crisis medicine. Well, it really is. It's also the responsibility and obligation to lead our fellow man towards a future even brighter then ever before!

Brooker L. Masters, MD

Donald K. Crandall, MD, of Muskegon (left), presides over first meeting of new MSMS Negotiating Committee for Third Party Carriers. Marion G. McCall, Jr., MD, MSMS Council member from Detroit, was invited to discuss third party practices with committee at organizational session June 12.

New MSMS Committee Tackles Third Party Insurance Problems

Elimination of some of the paperwork jumble that faces physicians and their office staffs in handling the varied forms used by third party carriers has been indentified as an initial objective of a new MSMS committee, authorized by the 1974 House of Delegates.

The committee held its first meeting June 12, under the chairmanship of Donald K. Crandall, MD, of Muskegon, named itself the MSMS Negotiating Committee for Third Party Carriers and immediately set to work on the problem of standardization of insurance forms.

The charge to the committee from MSMS delegates is to work for:

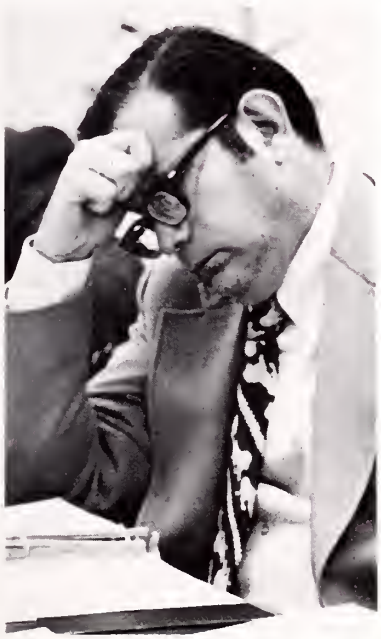
1. The adoption of a uniform coding system by all third party payors.
2. The use of a uniform health insurance claim for by all third party payors.
3. The abolishment of discriminatory reimbursement practices.
4. Identification and resolution of other closely related problems.

Members of the committee, along with Doctor Crandall, are John B. Bryan, MD, of Royal Oak; Jerome A. Conrad, MD, of Big Rapids; Donald N. Fitch, MD, of Escanaba; Thomas M. Flake, MD, of Detroit; Henry T. Forsyth, MD, of Chesaning; Richard H. Gascoigne, MD, of Adrian; Vickers C. Hansen, MD, of Manistee; Henry A. Kallet, MD, of Jackson; Mark C. Levine, MD, of Flint; Kenneth H. Musson, MD, of Traverse City; Orville W. Oughtred, MD, of Mt. Clemens; Homer M. Smathers, MD, of Detroit; Clark B. Smith, MD, of Hillsdale, and Harry Tarpinian, MD, of Livonia.

Donald N. Fitch, MD, of Escanaba (left), and Thomas M. Flake, MD, of Detroit bring Upper Peninsula and metropolitan points of view to committee discussions.

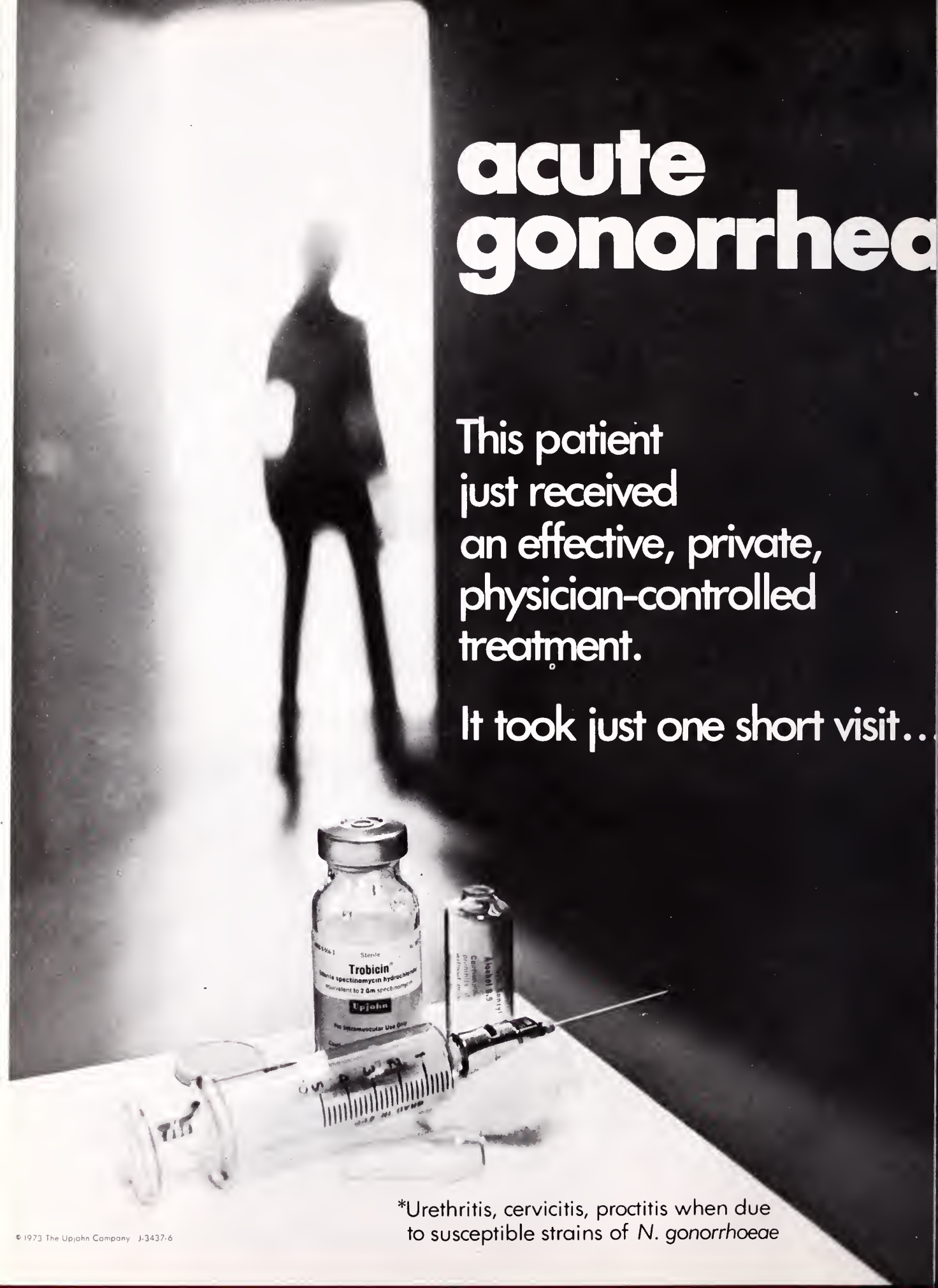
Clark B. Smith, MD, of Hillsdale, represents rural southern Michigan.

Orville W. Oughtred, MD, of Mt. Clemens (left); Henry T. Forsyth, MD, of Chesaning (center), and Mark C. Levine, MD, of Flint, attend to committee's initial concern with standardization of forms.



Henry A. Kallet, MD, of Jackson, studies questions before committee.

Homer M. Smathers, MD, of Detroit (left), and Richard H. Gascoigne, MD, of Adrian, concentrate on details during new committee's first session, held at MSMS headquarters.



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An ominocyclitol antibiotic active *in vitro* against most strains of *Neisseria gonorrhoeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between spectinomycin and penicillin.

Indications: Acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

Contraindications: Contraindicated in patients previously found hypersensitive to spectinomycin.

Warnings: Not indicated for the treatment of syphilis. Antibiotics used to treat gonorrhea moy mask or delay the symptoms of incubating syphilis. Patients should be carefully examined ond monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected.
Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions should be observed with atopic individuals.
Clinical effectiveness should be monitored to detect evidence of development of resistance by *N. gonorrhoeae*.

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single- and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25° C and use within 24 hours after reconstitution with diluent.

Male—Inject 5 ml intramuscularly for a 2 gram dose. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.

Female—Inject 10 ml intramuscularly for a 4 gram dose.

How supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of 400 mg spectinomycin per ml (as the hydrochloride). For intramuscular use only.
Susceptibility Powder—for testing *in vitro* susceptibility of *N. gonorrhoeae*.
Caution: Federal law prohibits dispensing without prescription.
For additional product information see your Upjohn representative or consult the package insert.

Upjohn MED B-5-S (MBR-1)
The Upjohn Company, Kalamazoo, Michigan 49001

†For patients with gonorrheal proctitis and for patients in geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams is preferred.

Letters

Oregon Woman Praises Oakland Co. Committee

Director
Michigan State Medical Society

Dear Sir:

I am writing to you to let you know that I think the Oakland County Medical Society and their Mediation committee deserve a lot of credit for their efforts in helping me solve a "problem" with my doctor. Harold A. Ott, MD, is the chairman of the Mediation Committee.

It really is not necessary to go into detail. Suffice it to say that the Mediation Committee and Doctor Ott handled the situation more than adequately. They did a lot of work they did not have to do. They listened to my complaint, although the problem wasn't really that earth shattering. But I couldn't solve the problem by myself. I tried. And it needed solving.

I feel the Oakland County Medical Society, their Mediation Committee and Doctor Ott deserve a round of applause for helping me.

Sincerely Yours,
Vernie Bettis
Portland, Ore.

Medical Schools Thank MSMS

Herbert A. Auer
Executive Editor
Michigan Medicine

Dear Mr. Auer:

On a number of occasions during the past two years, you have provided notable publicity and support which have been helpful in promoting the Cooperative Michigan Primary Care Preceptorship Program.

Your thoughtful assistance is enormously appreciated by us at Wayne State whose principal responsibility is recruitment (of preceptors) and, I am sure, by all members of the Program Operating Committee as well.

Very truly yours,

Alegro J. Godley, MD
Associate Professor and Acting Chairman,
Department of Family Medicine
WSU School of Medicine

Emergency Department Means Expanded Services

To the Editor:

The recent article by Bruce L. Danto, MD, published in the June, 1974, issue of *Michigan Medicine* (Attempted Suicide and the Emergency Room Doctor, **73**:315) was extremely illuminating. Doctor Danto's reference, however, to the "emergency room staff" was perhaps most illuminating.

The JCAH, the American College of Emergency Physicians and our own national organization (AMA) have all focused their attention on the development of emergency physicians (not emergency room doctors) and the improvement of emergency health care in all its aspects.

The Emergency Department Nurses Association has focused attention on the need for specialized nurses in this area of practice.

Many of the problems listed by Doctor Danto in the treatment of the suicide patient in the emergency department (not room) would be minimized if full-time emergency physicians and emergency nurses were to function in well-organized emergency departments.

Statistically, those hospitals that only maintain rooms are not now able to render the care for the suicide patient that Doctor Danto wishes.

Ronald L. Krome, MD, FACS
Associate Professor of Surgery
Director, Emergency Department
Wayne State University School of Medicine

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Opinion & Dialogue

Is there a need for a drug compendium?

Government Health Official

Henry E. Simmons, M.D.
Deputy Assistant Secretary for Health
Department of Health, Education and Welfare

A drug compendium of the type I envision would fill a definite need for the practicing physician. Such a compendium would give him all the information necessary for using a drug intelligently, and it would do so in a clear, concise, convenient, objective and balanced fashion.

What a Compendium Should Contain

I believe the compendium should inform the doctor what a drug will do, when he should use it, for what type of patient, for how long, in what dose, what benefits his patient is likely to obtain, the risks involved, and cross-reaction with other drugs.

The information would be based on the package insert and have the same legal status. In fact, a complete compendium with complete and current information might even eliminate the necessity

Maker of Medicine

Joseph F. Sadusk, Jr., M.D.
Warner-Lambert Company

A drug compendium, or preferably compendia, should, I believe, be private, not federal, in sponsorship. They should contain comprehensive listings of drugs available for prescribing. They should be single, legibly printed volumes of reasonable size, updated quarterly or semiannually and completely revised every year

Function of a Compendium

A compendium should furnish the following information on drugs in the following order: indications for use, side effects, adverse drug reactions, contraindications, drug interactions, drug dosage and the dosage forms marketed. Drug prices should not be included because they vary so widely and change rapidly.

No compendium should set forth drugs of choice or discuss relative efficacy. Such questions must be left for the practicing physician to decide, whether on the basis of the medical literature, his own clinical experience, advice of colleagues, information supplied by manufacturers, and so on.

Nor should a compendium undertake to educate the doctor on how to use drugs. Rather, it must be a reference source designed primarily to refresh his memory as to drugs he may not use regularly. It

r a package insert in many in-
ances. This would constitute a
ubstantial saving for the manu-
acturer.

By a complete compendium,
do not mean a volume of prohibi-
ve size. You don't need a book
escribing 25,000 products with
n enormous amount of repetition.
ather, drugs should be arranged
y class. Mutually applicable infor-
ation would be provided, along
ith brief discussions pinpointing
ifferences in specific drugs of
at class. Listings would be cross-
ndexed in a useful way.

**ther Available Documents as
ources of Information**

Existing references such as
DR and the AMA Drug Evaluation
e obviously useful but they are
complete. Either they are not
oss-referenced by generic name
nd do not group drugs with simi-
r characteristics, or they do not
st all the available and legally
arketed drugs. And some of
ose omitted may be very useful.

On the other hand, drugs made by more than one supplier, tetracycline for example, may be fully described a dozen times in the same book.

While perhaps PDR could be rearranged and cross-indexed with generics included, and while the AMA Drug Evaluation might also be modified and expanded, I am not sure that the end result would have all the attributes required for a useful compendium. At the same time, you would run the risk of amassing a voluminous and unwieldy tome.

Should Editorial Comments Accompany the Listings?

Subjective judgments, in my opinion, have no place in a compendium. However, if there is substantial evidence based on a sound body of science concerning relative efficacy of several drugs, certainly that information should be included. The committee of experts compiling and editing a particular section would also have to assess and indicate instances where a meaningful difference between drugs is pertinent.

Sponsorship, Compilation and Editing

Producing a book like this would undoubtedly be difficult and demanding. It would obviously take a great deal of talent and expertise, and would require a varied and experienced group, ranging from writers and editors to highly skilled clinicians and pharmacologists. Style, format and clarity of language would play an important part in determining the usefulness of the book. And it should be updated periodically and completely revised annually.

I have no opinion whether the government or the private sector should sponsor and/or finance the compendium. What is most important is that the compendium be an authoritative, objective and useful source of information for the doctor to have at hand as a ready reference.

---

ould in no way imply control over
e practitioner's prerogatives.

/hy Another Compendium?

A practicable, single-volume
ompendium cannot, nor is it
ecessary to, include all drugs on
e market today. From my prac-
ce of internal medicine for some
5 years, my experience as a con-
ultant, and as a faculty member
f four or five medical schools, I
ould estimate that a doctor uses
nly 30 to 35 drugs regularly. The
972 Physicians' Desk Reference,
cidentally, contained about
,500 entries.

As to whether there should be
federal compendium, in my opin-
n, as stated earlier, the answer is
asy—there should *not* be one. The
roposal assumes that existing
ompendia are inadequate. We're
ot sure of that at all. Whatever its
nperfections, the present drug
nformation system in the U.S. is
pen, multifaceted, pluralistic and
xtensive. Good compendia exist,
s well as other ample sources on
rug therapy, ranging from journal
terature through AMA Drug Evalu-
tion to company materials. Not
ll physicians may use such
ources as often or as well as they
hould, but that is the fault of the
an, not of the sources.

In any event, rather than produce another book, it makes much more sense to work on improving existing compendia, and perhaps they could, as knowledge advances, include more accumulated clinical data and experience, and more information on drug interactions and adverse reactions.

Implications of a Federal Compendium

Take a hard look at the implications of a federal compendium. It would have the force of law, virtually dictating what drugs to use and how to use them. In effect, it would be a regulatory document with legal or quasi-legal status, posing medical/legal problems similar to those the doctor may now encounter if and when he departs from the provisions of the package insert. A compendium under federal aegis would tend to restrict decisions on drug therapy to one orthodox level—a most dangerous trend for medicine.

New Compendium—A Medical Option

I detect no ground swell of initiative or support whatsoever for a federal compendium—or, for that matter, for a new compendium of any type. A 1969 PMA survey conducted by Opinion Research Corporation found that only 15 per cent of those physicians interviewed felt a new compendium was needed. And a large majority did not favor the involvement of the federal government if one were to be created, preferring instead a nongovernmental consortium.

Even if we come to a time when the medical profession itself opts for a new kind of compendium, it should be handled and financed, ideally, outside both government and industry. Final review and editorial authority could be delegated, say, to specialty bodies and medical societies—but above all, *not* the government.

Surely the health care system in the United States has far more vital matters to consider than the extensive cost and effort that would have to go into the preparation and maintenance of a new, monolithic compendium, and especially one bearing the imprimatur of the federal government.

Opinion & Dialogue

What is your opinion, doctor? We would welcome your comments.

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Scientific Articles

Penicillamine for Rheumatoid Arthritis

By William S. Reveno, MD, and Herbert Rosenbaum, MD, Detroit

For the patient with longstanding therapeutically unresponsive rheumatoid arthritis, D-penicillamine, as recently reported,[1] may be of benefit in treating such patients. The following report describes a pilot study in the use of penicillamine in one such patient.

This 49-year old white woman with rheumatoid arthritis for 13 years has been under our care for the last nine years and recently treated with penicillamine for 14 months. She had the characteristic painful swelling and stiffness of the fingers, hands, wrists, shoulders, knees and ankles. Initially the ESR was 30 mm/hour and intramuscular gold salts were given weekly resulting in a brief remission after three months. Thereafter, with few exceptions, symptoms persisted in spite of continued administration of gold salts together with a wide variety of oral antirheumatic agents. In at least five instances knee and ankle joint effusions were drained and hydrocortisone injected. Then two years ago to add to her troubles she was involved in an auto accident in which she suffered a whiplash of the cervical spine requiring corticosteroids and narcotics for relief.

Following a full explanation of the potential risks of penicillamine therapy and with her full consent, treatment was started with 250 mg. D-penicillamine *(Cuprimine — Merck-Sharp and Dohme)* daily. After one week the dosage was incresed to 250 mg. twice daily and again increased after another two weeks to 250 mg. three times daily. Just as she was beginning to experience some relief she abruptly stopped treatment on her own for two weeks explaining this in her own words as a "teen age rebellion against regulation." Former symptoms promptly recurred and the rebellion ended.

Penicillamine was restarted at the previous dosage level with slow continuous relief of symptoms. After three months on 250 mg. three times daily it was increased to four doses daily. Now there was very little joint pain or stiffness, only some neck pain resulting from the accident. Activity was no longer restricted and joint swelling was markedly reduced. There was a gradual weight loss of 5 Kg during the first four months of treatment but 3 Kg were regained during the next ten months. At the end of the eighth month the dosage of penicillamine was reduced to 250 mg. three times daily without loss of benefit and is presently being continued at this level. A 4 cm. nodule over the left olecranon process was now reduced to 1 cm. At the end of 14 months her general appearance, mobility and well-being, she now claimed, were as they were before she developed rheumatoid arthritis.

So far no adverse reactions have occurred. The blood pressure has ranged between 130 and 150 mm. systolic and 80 to 90 mm. diastolic; the ESR moved from 30 mm. to a present reading of 8 mm/hour; shortly after starting therapy platelets were 78,000 and then rose steadily to 142,000 at the most recent reading. The blood hemoglobin ranged from 10.7 to 12.5 gm.; the red cell count from 4.54 million to 4.47 million per cu mm.; the white cell from 6950 to 8500 per cu mm., and the differential count remained at normal levels throughout. At no time was there proteinuria. The latex fixation test was unaccountably negative both before and during treatment.

In this one patient treated for 14 months penicillamine has so far accomplished more than all previous treatments. However, the duration of benefits is still to be determined and undesirable side-effects have not been ruled out.

Jaffe,[2] who has had longest experience, gives penicillamine after meals at an optimum dose of 1.5 gm. a day, a level usually achieved after 12 to 14 weeks. Failure to show improvement after six months on the maintenance dose calls for abandonment of the treatment.

Even if this treatment does no more than achieve remissions equivalent to those following gold salts it will have added a promising method effective for those with rheumatoid arthritis unresponsive to the presently used anti-inflammatory and analgesic agents.

References

1. Controlled trial of D(-) penicillamine in severe rheumatoid arthritis, Multicenter trial group. *Lancet* 1:275-280, (Feb. 10 1973.

2. Jaffe IA: The treatment of rheumatoid arthritis and necrotizing vasculitis with penicillamine. *Arthritis and Rheum* 13: 436-443, 1970.

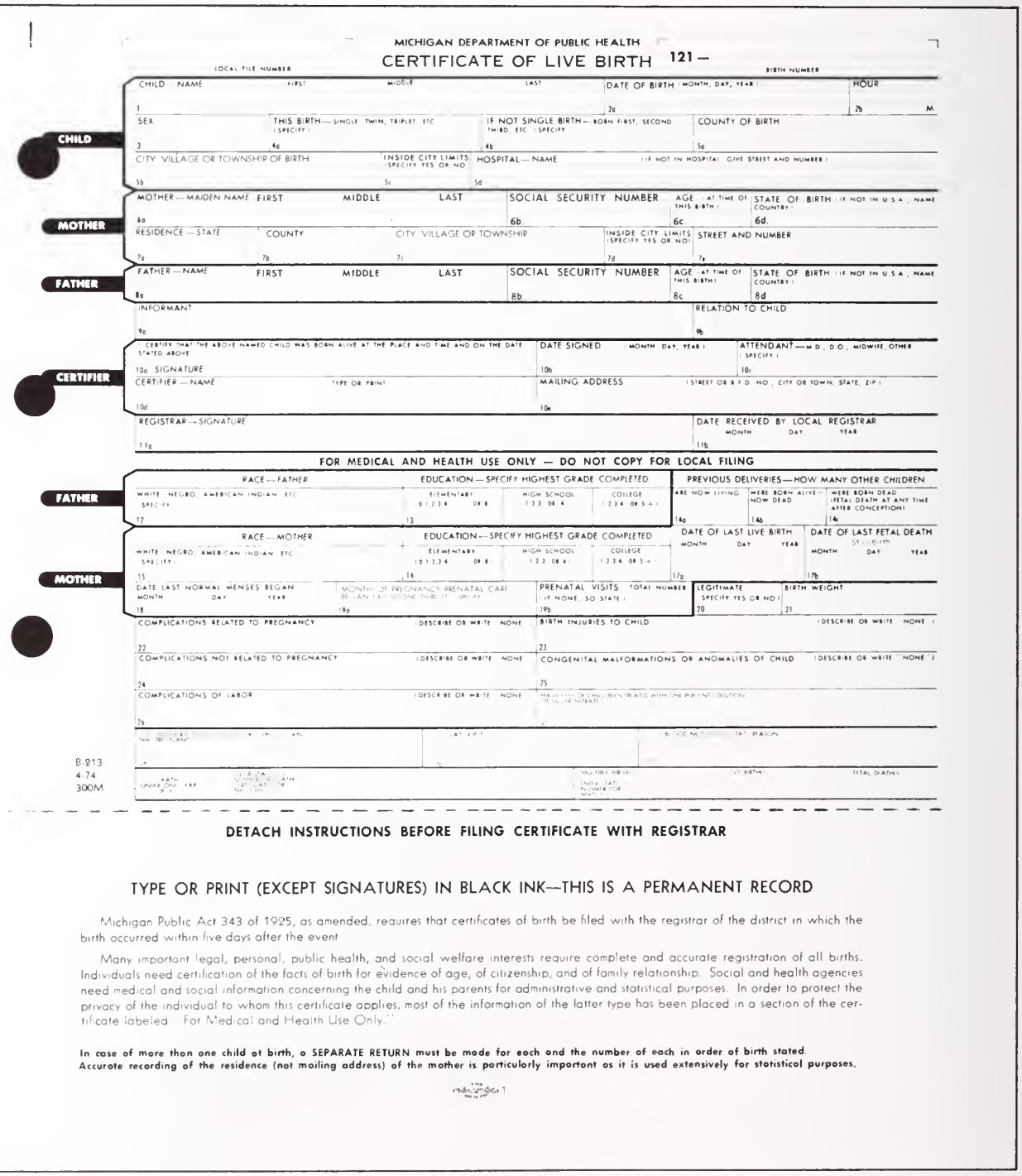
Please address requests for reprints to William S. Reveno, MD, 968 Fisher Bldg., Detroit, Mich. 48202.

Michigan Changes Birth Certificate Form

The Michigan Department of Public Health has asked the cooperation of all physicians who deliver babies in using the new form for registration of live births required in the state as of July 1. The new form was drafted after action by the state legislature last year requiring that birth certificates include a record of the social security numbers of the mother and father of the child.

MDPH has asked that all copies of the form in use prior to July 1 be destroyed.

New Registration Form



MICHIGAN DEPARTMENT OF PUBLIC HEALTH

CERTIFICATE OF LIVE BIRTH 121 —

LOCAL FILE NUMBER — BIRTH NUMBER

CHILD — NAME (FIRST, MIDDLE, LAST) — DATE OF BIRTH (MONTH, DAY, YEAR) — HOUR

SEX — THIS BIRTH — SINGLE, TWIN, TRIPLET, ETC. (SPECIFY) — IF NOT SINGLE BIRTH — BORN FIRST, SECOND, THIRD, ETC. (SPECIFY) — COUNTY OF BIRTH

CITY, VILLAGE OR TOWNSHIP OF BIRTH — INSIDE CITY LIMITS (SPECIFY YES OR NO) — HOSPITAL — NAME (IF NOT IN HOSPITAL, GIVE STREET AND NUMBER)

MOTHER — MAIDEN NAME (FIRST, MIDDLE, LAST) — SOCIAL SECURITY NUMBER — AGE (AT TIME OF THIS BIRTH) — STATE OF BIRTH (IF NOT IN U.S.A., NAME COUNTRY)

RESIDENCE — STATE — COUNTY — CITY, VILLAGE OR TOWNSHIP — INSIDE CITY LIMITS (SPECIFY YES OR NO) — STREET AND NUMBER

FATHER — NAME (FIRST, MIDDLE, LAST) — SOCIAL SECURITY NUMBER — AGE (AT TIME OF THIS BIRTH) — STATE OF BIRTH (IF NOT IN U.S.A., NAME COUNTRY)

INFORMANT — RELATION TO CHILD

CERTIFIER — I CERTIFY THAT THE ABOVE NAMED CHILD WAS BORN ALIVE AT THE PLACE AND TIME AND ON THE DATE STATED ABOVE — DATE SIGNED (MONTH, DAY, YEAR) — ATTENDANT — M.D., D.O., MIDWIFE, OTHER (SPECIFY)

SIGNATURE — CERTIFIER — NAME (TYPE OR PRINT) — MAILING ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP)

REGISTRAR — SIGNATURE — DATE RECEIVED BY LOCAL REGISTRAR (MONTH, DAY, YEAR)

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FATHER — RACE — FATHER (WHITE, NEGRO, AMERICAN INDIAN, ETC. SPECIFY) — EDUCATION — SPECIFY HIGHEST GRADE COMPLETED (ELEMENTARY 0 1 2 3 4 5 6 7 8; HIGH SCHOOL 1 2 3 OR 4; COLLEGE 1 2 3 4 OR 5+) — PREVIOUS DELIVERIES — HOW MANY OTHER CHILDREN (ARE NOW LIVING; WERE BORN ALIVE — NOW DEAD; WERE BORN DEAD (FETAL DEATH AT ANY TIME AFTER CONCEPTION))

MOTHER — RACE — MOTHER (WHITE, NEGRO, AMERICAN INDIAN, ETC. SPECIFY) — EDUCATION — SPECIFY HIGHEST GRADE COMPLETED (ELEMENTARY 0 1 2 3 4 5 6 7 8; HIGH SCHOOL 1 2 3 OR 4; COLLEGE 1 2 3 4 OR 5+) — DATE OF LAST LIVE BIRTH (MONTH, DAY, YEAR) — DATE OF LAST FETAL DEATH (STILLBIRTH) (MONTH, DAY, YEAR)

DATE LAST NORMAL MENSES BEGAN (MONTH, DAY, YEAR) — MONTH OF PREGNANCY PRENATAL CARE BEGAN (1ST MONTH, 2ND MONTH, 3RD MONTH, ETC.) — PRENATAL VISITS TOTAL NUMBER (IF NONE, SO STATE) — LEGITIMATE (SPECIFY YES OR NO) — BIRTH WEIGHT

COMPLICATIONS RELATED TO PREGNANCY (DESCRIBE OR WRITE NONE) — BIRTH INJURIES TO CHILD (DESCRIBE OR WRITE NONE)

COMPLICATIONS NOT RELATED TO PREGNANCY (DESCRIBE OR WRITE NONE) — CONGENITAL MALFORMATIONS OR ANOMALIES OF CHILD (DESCRIBE OR WRITE "NONE")

COMPLICATIONS OF LABOR (DESCRIBE OR WRITE NONE) — (MAJOR CHILD BIRTH RELATIVE WITH ONE BIRTH RESOLUTION OF SOLE NITATE)

B-213
4-74
300M

DETACH INSTRUCTIONS BEFORE FILING CERTIFICATE WITH REGISTRAR

TYPE OR PRINT (EXCEPT SIGNATURES) IN BLACK INK—THIS IS A PERMANENT RECORD

Michigan Public Act 343 of 1925, as amended, requires that certificates of birth be filed with the registrar of the district in which the birth occurred within five days after the event.

Many important legal, personal, public health, and social welfare interests require complete and accurate registration of all births. Individuals need certification of the facts of birth for evidence of age, of citizenship, and of family relationship. Social and health agencies need medical and social information concerning the child and his parents for administrative and statistical purposes. In order to protect the privacy of the individual to whom this certificate applies, most of the information of the latter type has been placed in a section of the certificate labeled "For Medical and Health Use Only."

In case of more than one child at birth, a SEPARATE RETURN must be made for each and the number of each in order of birth stated. Accurate recording of the residence (not mailing address) of the mother is particularly important as it is used extensively for statistical purposes.

Observations on the Personality of the Obesity Patient

By Joel I. Hamburger, MD, FACP, Southfield

Introduction

Obesity is one of the most important public health problems in the United States today. Life insurance statistics indicate that persons 50 pounds over their ideal weight have a one-third increase in mortality rate, and those with 80 pounds of excess weight have more than double the expected mortality rate. The obese have a higher incidence of diabetes mellitus, hypertension and coronary artery disease. Complications following elective or emergency surgery are more common. Beyond the physical disadvantages there are significant social problems. Opportunities for employment are limited, and so is the likelihood of advancement. Prospects for marriage are reduced, and the stability of an existing marriage may be impaired. The adverse effects of obesity are suffered not only by the overweight person himself, but they are also visited upon his children; for the offspring of the obese have a much greater probability of in turn developing obesity.

Everyone agrees that obesity is bad, and that the overweight should reduce. Unfortunately the majority of obese people seem to be unable to achieve any sustained weight reduction.

Inevitably in the course of my daily activities as a thyroidologist I see many patients for whom obesity is either the presenting complaint, or a prominent complicating factor. As a result, I have observed certain particularly common patterns of behavior and thinking which serve to deter the obese patient from realizing success with weight reduction. I believe that these observations may be helpful to others who deal with this problem.

The Evolution of Obesity

Recognizable obesity may have its onset at almost any time in life. It is common to obtain a history of onset when the child enters school, at adolescence, or following childbirth. Those who escape the obesity of early life are still subject to middle age spread or senescent obesity.

Many patients claim that they have been obese all their lives, and there is some truth in this attitude. An overprotective insecure mother may place undue emphasis upon eating. The infant soon learns that eating earns him a loving reward. In time an altered setting of the central nervous system satiety center is produced so that only an excessive food intake proves satisfying. This may in part explain the observation that 75 per cent of obese children maintain or increase their obesity as they grow into adulthood.

Regardless of the time of onset of obesity psychological factors seem frequently to be operative. The overeating provides a real substitute for the fulfillment of needs that have not been met, and realistically are not likely to be met. Furthermore the obese patient is subjected to continuing encouragement to persist in his eating by the advertising profession via radio, television and other media which redundantly demonstrate the satisfactions to be achieved by indulging in food. Social situations place additional burdens upon the resolve of the obese patient, as well-meaning friends and relatives encourage him to eat today, and diet tomorrow. They do not realize how cruel this advice is to the struggling dieter. These powerful incentives to continue overeating compound the problem, and may render all efforts at correction unsuccessful.

Once a pattern of overeating has been established it tends to be perpetuated by certain characteristic habits and notions.

Faulty Habits

Obese individuals tend to fall into either of two categories with respect to eating habits.

Gross Overeating. The gross overeaters eat too much of all types of food at all meals, and in between as well. These constitute a minority of the obese patients seeking medical help. Gross overeating is either voluntary and deliberate, or the result of intellectual impairment or immaturity. For these patients there is neither regard nor concern for the consequences of their obesity and by and large they are content to pursue their faulty eating habits. At the behest of relatives, some of these patients may make an occasional half-hearted effort at weight reduction, but they seldom persist for very long. Probably best included with

(Continued)

From the Northland Thyroid Laboratory, Southfield.

these patients are those whose obesity is the outward manifestation of a severe emotional disorder. Food has become so important and its deprivation so threatening that any meaningful attempt at weight reduction is impossible without a rather profound restructuring of the personality. My subsequent remarks exclude these gross overeaters. There is no effective, practical and generally applicable approach to their management.

Overeating On Balance. The patient more likely to seek medical attention for obesity is not a gross overeater. It is a mistake to assume that all or even most obese patients are gluttons, in the usual sense of the word. In fact many do not seem to be overeating at all, as we usually think of overeating. However, it is essential to define overeating apart from the usual stereotype of normalcy, which includes the concept of the balanced diet to which we were all exposed in grade school hygiene classes. Overeating simply means eating more food than the body needs. Note that the emphasis is upon body needs, not the quantity of food ingested per se. The excess intake of 3,500 calories will produce a weight gain of about one pound. Thus an average intake of 100 calories per day in excess of body needs may produce a 10 pound weight gain per year, 30 pounds in three years, 100 pounds in 10 years. One slice of bread, an apple or five ounces of milk contain about 100 calories. No glutton worthy of the name would demean himself with such trivial overeating. Yet the consistent ingestion of even this amount of excess food may lead ultimately to obesity of monumental proportions.

This is not to imply that most obesity is the consequence of a small but regular excess intake, far from it. Much more common is the habit of periodic dieting punctuated by intermittent binges of varying length during which relatively enormous quantities of food may be consumed. In a single meal 3,000 or more calories may be ingested. These binges are often taken on weekends as rewards for faithful dieting during the week. The patient fails to appreciate that the rewards more than compensate for the prior caloric conservation and produce an overall positive caloric balance.

While dieting, the usual pattern of eating provides minimal caloric intake at breakfast and lunch, with a healthy supper, sometimes followed by evening snacks. Skipping breakfast and lunch only sharpens the appetite at supper, making it more difficult to curtail the intake, and easier to justify a larger meal than desirable. After all: "I haven't eaten all day." Furthermore there is experimental evidence that this pattern of eating tends to promote a greater deposition of fat than would be the case with the ingestion of the same quantity of food, divided in three meals. These irregular eating habits make any attempt at an assessment of the average caloric content of the diet by history a very difficult undertaking.

Qualitative Aspects of Overeating. Qualitative factors in the diet also must be considered. Carbohydrates are converted into fat with less expenditure of energy than is the case for protein. Even a cursory investigation into the dietary habits of the obese commonly reveals a preference for bread, potatoes and other starches, not to mention sweets.

Physical Activity. In addition to faulty eating habits, lack of physical activity compounds the obesity problem. Many obese patients recognize their relative physical indolence. Others labor under the mistaken impression that they are very active, simply on the basis of routine household or business chores. To be sure this is a greater level of activity than bedrest; but to contribute significantly to a weight reduction program physical activity must be considerable and regular. For example, one hour of jogging comsumes 600 calories; of swimming at a moderate rate, 500 calories; of cycling strenuously, 600 calories. By contrast, floor mopping, truck driving, ironing or food preparation utilize only about 200 calories per hour. Since the elimination of one pound of body fat necessitates the consumption of 3,500 calories, the following conclusions as to the role of physical activity in a weight reduction program seem justified:

1. To be useful, exercise must be regular, vigorous, and prolonged;

2. One hour of vigorous exercise daily — every day — will result in the caloric consumption equivalent to one pound of fat per week;

3. Since most people are unable to exercise either so vigorously or so regularly, exercise, although important, must be viewed as of supplemental value in a weight reduction program — for which caloric restriction is the keystone.

Faulty Notions

In addition to faulty habits, certain faulty notions manage to creep into the thinking of the obese individual and serve to inhibit efforts at corrective action.

Notions About Eating. "I really don't eat *that much.*" "I have to starve myself to lose weight." "When I eat *normally* I gain." "I *have* to eat some bread or potatoes or I won't have a balanced diet." "I can gain 10 pounds overnight!" *("Aren't you shocked, Doctor?")* "If I don't eat, I can't work." "I eat much less than my friend, and I gain while she stays thin." "I've tried every diet, and even if I lose a little at the beginning, I soon level off and sometimes even gain; so I just give up and go back to eating *normally.*"

Note that there is some truth to each of these statements. As we have already seen, it is not necessary to eat "that much" to gain a con-

siderable amount of weight. The concept of a "normal, balanced" diet as rooted in the lay mind is a distortion of fact and must be revised if progress with weight reduction is to be achieved. The most important element in this revision is an understanding of the nonessential nature of foods composed solely or predominantly of carbohydrates *(starches and sweets).* One cannot only survive, but enjoy excellent health without them.

Obese patients frequently describe the disastrous weight gain which occurs when they eat "normally." Although eating "normally" surely means something quite specific to the patient, it means something quite different from patient to patient, and not very much at all to the physician. It is essential that the patient adjust his thinking to appreciate that what is normal for him is no more than what is required to maintain a normal body weight. Therefore, by definition one who is obese, or gaining weight has not been, or is not, eating normally. The intake has exceeded body needs, and the excess calories have been stored as fat. Even if the patient does not eat "that much," it is too much for him.

Note the call for sympathy in the claim that "I must starve myself to lose," and the thinly veiled hostility in the statement "If I don't eat I can't work!" The patient knows she is not going to starve by dieting, and she knows that the doctor knows it. She does not have to be told that she has enough stored energy in her fat depots to do a great deal of work, even without eating, and can easily and safely carry on with a low caloric diet. These exaggerations simply reflect a desperate need for understanding and acceptance. They are frequently accompanied by a flow of tears expressing the underlying emotional intensity.

What obese patient has not tried dieting prior to consulting a physician? But what does she mean by trying, and what types of diets did she try. Trying may mean anything from a few days to a few weeks. When 20 pounds do not melt away the diet is considered a failure. If one asks the obese patient what one could reasonably expect to lose on a proper diet the usual response is 4-5 pounds per week or more, even from intelligent patients. To lose 4 pounds in one week would require an intake of 14,000 calories (3,500 calories per pound) *less* than the body burned, or 2000 calories per day *less* than needed. Since few obese patients require as much as 2,000 calories per day total, to lose 4 pounds per week the patient would have to eat less than nothing — clearly absurd. In fact, a daily intake of 500 calories less than needed is a very satisfactory dietary performance from the long-range point of view. However, this will only lead to a weight loss of one pound weekly ($7 \times 500 = 3{,}500$).

This analysis bears directly upon the common claim that "I can gain *(lose)* 5-10 pounds overnight." Generally these weight swings follow a large meal. However, most of what is weighed is water, and this is excreted in the urine rather rapidly. In addition, there is solid waste which eventually passes with the feces. Urine, excess extracellular fluid and fecal matter are all within the body, and contribute to total body weight, but are not constituents of body tissues. The temporary retention or excretion of these materials may produce dramatic changes in total body weight, while there is essentially no change in the body tissue weight. Over a longer period of time, e.g. several weeks, shifts in these substances balance out and one can obtain some indication of whether there has been a change in body tissue weight. This assumes that the weight is measured by a reliable scale, at the same time of day, preferably after an elimination and without clothing. Since patients seldom pay attention to these details, and even less often have available a reliable scale, their reports of weight changes are of dubious value.

Unscrupulous diet quacks take advantage of the effects of laxatives and diuretics to convince their clients that they can produce a rapid and dramatic weight loss. Naturally these losses are not sustained, but there is a new crop of victims every day.

The obese patient, constantly searching for magical remedies is always on the alert for the latest fad diet. Since these diets are conceptually and practically unsound, their proponents have lately found themselves either in jail or in litigation. Thus there is a constant need for new fads. Nevertheless, just as surely as nature abhors a vacuum, the demand for fad diets produces a never ending supply — a tribute to the imagination of the hustlers.

Any diet that deviates from a pattern of eating which would be permanently suitable is ipso facto conceptually unsound. Obesity is not a problem for a week or a month, it is a life-long problem. Fad diets actually are harmful since they distract the patient from this essential reality, and only serve to delay his coming to terms with the necessity of learning what and how to eat for the rest of his life. Furthermore, fad diets encourage the natural inclination of the patient to live in the fantasy world of magic, where sooner or later the correct wand will wave away all troubles.

At the risk of redundancy, I shall add that fad diets are not acceptable even to "get the patient started." The problem is not getting started. No matter what method is employed almost all obese patients do well for the first few weeks. It is the need for persistent and consistent dieting that leads to failure.

Finally, in some cases fad diets have actually been shown to be unhealthy, particularly for the obese.

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Notions About Disease As A Cause of Obesity. "There must be something physically wrong with me." "It's my glands (endocrines are cited by the more sophisticated)." "It's really mostly fluid, all bloat!" The desire to find some explanation, other than the obvious is exceedingly intense in obese patients.

After all, if they are sick, they are not to blame. Furthermore, it is the doctor's fault because in the first place he does not know enough to find out what is wrong; and secondly, he failed to administer the proper remedy. Emphasis upon miraculous scientific breakthroughs in the lay literature (*most of which, of course, are ultimately shown to have no more value than yesterday's newspaper*), in conjunction with a multitude of fraudulent publications with promises like "calories don't count" serve to reinforce the notion that there is really some simple medical solution to the obesity problem.

It is particularly popular to blame the endocrine system, especially the thyroid gland for obesity. In fact, endocrine disease, including hypothyroidism is never the sole cause of obesity and seldom is even a contributing factor. Nevertheless, it is a rare obese patient who has not been given thyroid hormone at some time in a fruitless attempt at correcting nonexistent hypothyroidism. To add irony to irony, the dosage of thyroid hormone employed is often homeopathic.

The fluid retention problem, upon which obese patients frequently dwell at great length, is an example of a notion about which there is some truth. There is a tendency for fluid retention in obese individuals, especially when dieting. Nevertheless, this fluid ultimately is excreted, whether diuretics are given or not. Fluid retention never contributes more than a fraction of the obese person's superfluous poundage. Fluid retention may be particularly uncomfortable in the week or two preceding menstruation, a time when this problem seems to be annoying even for nonobese women. The use of diuretics may be justifiable to promote fluid excretion, but diuretics do not begin to solve the obesity per se.

Notions About The Role Of The Physician: "Why won't you give me some shots or pills to make me lose weight or curb my appetite — if only just to get me started?" "Doctor, you don't want to help me!" Diet pills (*or capsules*) have been consumed by the millions, perhaps by the billions. They come in all sizes, shapes and colors. New models come out yearly like the autos. However, is there any data to suggest that there is less obesity as a result? Should it not be obvious that if any of the many diet medications were truly effective there would be no need for a host of competitors? Although diet pills have been available for many years, where is the study to show that the use of any of these medications has resulted in a significant weight loss in any sizable population of obese patients which was sustained for ten years, or five years, or even two years? There is no convincing evidence that diet pills have made any real contribution to the management of obesity.

On the contrary there are valid objections to the use of these drugs in a weight reduction program, in addition to the potential for abuse. The ordering of drugs serves to reinforce the faulty notion that obesity is the result of some physical abnormality that requires medication to correct. The implication is that weight loss is produced by the pill. Therefore, no weight loss simply means the wrong pills. If the physician attempts to explain the uselessness of diet drugs, unless this is done with great tact and persuasion, it may be interpreted as a rejection of the patient. After all the patient did not come to reduce, but rather to be reduced.

These faulty notions reflect attitudes of the obese patient which constitutes a major barrier to the achievement of weight reduction. These attitudes may be summarized as follows:

1. *It is not my fault that I am overweight.*
   a. It is not that I eat too much, it is just that my body does not burn up the food properly.
   b. Furthermore I have done everything that can be expected of me, including all kinds of diets, diet pills and consultations with many diet specialists.
2. *If anyone is to blame it is the doctor.*
   a. Why doesn't he find out what is wrong with me?
   b. Why doesn't he give me the right medication?
   c. I have paid to be reduced, but have not been helped.
   d. If the greatest minds in medicine are stumped by my problem, what can you expect from me?

Thus, the physician who attempts to treat obesity must deal with a patient quite different from that for which most of his training has prepared him. There are powerful and realistic motivating factors which induce the patient to perpetuate his disease, whereas the cure is unpleasant and protracted. When the patient consults a physician it may not be solely for the purpose of obtaining his advice, for the advice is obvious. The patient may desire and expect magic, and if the physician fails to fulfill these unrealistic expectations, as far as the patient is concerned, the failure is that of the physician, and it is the physician who should bear the onus for the continuing obesity.

Obviously any physician who hopes to accomplish something of lasting value with obese patients cannot play the game by these rules. Therefore establishing proper ground rules should be an item of top priority in any weight reduction regimen. Assisting the patient to understand certain unalterable facts of life will be helpful in this regard.

Facts of Life for the Obese

I. ***Obesity Results From Overeating.*** This is true for every obese person regardless of age, sex, activity status or the presence of other illness which might affect weight. Overeating does not necessarily imply gluttony. It is possible to eat rather small quantities of food and still be overeating. Overeating simply means eating more than the body needs.

II. ***There is No Disease, Endocrine or Otherwise, the Correction of Which Will Eliminate Obesity.*** Patients with hypothyroidism may be obese, but may also be underweight. The average deviation and range of deviations from normal weight is not different from that observed for patients with normal thyroid function. Diabetes mellitus is also associated with obesity. However, it seems more likely that the obesity is an aggravating factor for the diabetes, than that the diabetes causes the obesity. In any event, for both hypothyroidism and diabetes, obesity when present indicates overeating. Neither correction of hypothyroidism nor control of blood sugar will correct the associated obesity without caloric restriction.

III. ***Once Established, Obesity is a Problem for Life.***

IV. ***There is No Magical Remedy for Obesity.*** There is no magic diet. There are no magic pills or injections. There are no magic physicians. No physician has any secret remedy not available to all other physicians. No medication ever reduced an obese patient, and no physician ever reduced an obese patient.

V. ***The Only Way to Lose Weight is to Eat Less Than the Body Needs, Consistently.*** The only way to keep weight down is to continue to curtail food intake for life.

VI. ***A Proper Mental Attitude is Essential to Weight Reduction.*** If one thinks of dieting as "starving," "eating nothing," "suffering," "self denial," "abnormal," it will soon become impossible to persist. The truth is that dieting is eating normally, perhaps for the first time in many years. Dieting restores, preserves and prolongs health and life. Dieting is no more unpleasant than many other experiences which are part of life. Dieting will be less difficult to bear if viewed as a healthier way of living not only for the patient, but for the rest of the family as well.

In addition to hunger in its various forms, many patients develop other symptoms while dieting. These include headache, constipation, weakness, irritability, tension, nervousness and sleeplessness. These symptoms do not mean starvation or serious disease. Concentration on the purposes of the diet and the benefits to be realized will help one to tolerate these symptoms. Equally unpleasant and even more sever symptoms can be borne with equanimity by a determined patient. A case in point is the recent popularity of natural childbirth. With proper mental and physical preparation, considerable discomfort can be tolerated without pain medication. The mother chooses to accept this discomfort for the welfare of her baby and other related motivating considerations.

VII. ***Acceptance of the Facts of Life is Essential for Successful Dieting.*** If the patient cannot adjust to these realities there is no point in pursuing the matter.

The Physician's Role in the Treatment of Obesity

The treatment of obesity is caloric restriction. I can offer no useful elaboration. I have no special diet, no wonder drug, no new method to foster motivation. In fact the constructive role of the physician in the management of obesity patients is limited, but may be considered briefly under the following headings:

Evaluative. The physician is needed for the necessary appraisal of emotional, intellectual and physical resources and limitations upon which decisions as to the suitability of a program of dieting and exercise must be based.

Educational. Instruction in proper eating habits, food selection, and most of all in the elimination of self defeating notions is important for successful treatment.

Counseling. Occasionally the physician may be of assistance in helping the patient make adjustments or accommodations to personal problems at home or work which are aggravating factors. Alternatively, it may be necessary to suggest formal counseling or even psychiatric evaluation.

Support. The sympathy and understanding of a physician may be helpful, particularly with patients who exhibit strong dependency needs. Reassurance and encouragement by a medical authority can help the patient survive periods of discouragement and depression over lack of progress.

Analytical. Analysis of diet records for unrecognized sources of "hidden" calories, and serial weight and measurement determinations are useful services which the physician can provide.

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Avoid Being Part of the Problem. The physician must avoid assuming an attitude suggesting that by virtue of his special skill and expertise he will solve the patient's problem. Obesity is the patient's problem, and only the patient can solve it. The physician must not allow the patient to manipulate the doctor-patient relationship to place the responsibility for success or failure upon the physician. The physician should not encourage the patient to rely upon drugs or fad diets, but should advise and pursue a long range perspective of the problem.

The Physician's Reaction to the Personality of the Obesity Patient

The primary purpose of this paper is to indicate that personality problems with the obesity patient may increase the difficulties of weight reduction. The limited role which the physician may play also has been emphasized. At this point it seems proper to consider the danger that physician attitudes also may serve to perpetuate obesity.

Although it is axiomatic that a physician should not become emotionally involved with his patients, for the obesity patient, adherence to this principle may be difficult. Lacking complete understanding of the underlying pathophysiology, having no specific and effective remedy to offer and appreciating that regardless of what is done, the long-term prospects for control are poor, the physician may feel insecure in his relationship to obesity patients. When an insecure physician faces a hostile patient, the result is hardly conducive to effective problem solving. The physican may completely reject the patient, refusing even to evaluate him on the grounds that it is not a medical problem, and he is too busy taking care of "sick" patients. The rejection may be less overt, but just as complete if the patient is bruskly advised to eat less and exercise by pushing away from the table. Rejection may be compounded by a challenge of veracity if the physician insists that the patient is eating more than is admitted.

In addition to being crude, cruel and ineffective, these approaches signify an abdication of the physician's responsibility to be as helpful as possible, even in a situation for which the prospects do not seem promising. The physician may be able to cope with these patients more effectively if he makes it clear at the outset that he can serve only in an advisory capacity, and that the responsibility for success or failure will remain squarely upon the shoulders of the patient.

Conclusions

1. The cause of obesity is overeating.

2. The control of obesity is accomplished by caloric restriction.

3. The combined effects of faulty habits and notions is to deter the patient from successfully achieving a sustained reduction in weight. These habits and notions are reinforced by the profound need for patient self vindication.

4. An understanding of the personality of the obesity patient is essential if the physician is to avoid both being manipulated by the patient into accepting responsibility for the problem, and contributing to the patient's problem by suggesting simplistic solutions.

5. The role of the physician in management of obesity is limited.

6. The physician should not permit his own feelings of insecurity to impair his effectiveness.

Effect of Vascular Implantation on Experimental Renovascular Hypertension:

A Comparison of Two Techniques

By Mark C. McQuiggan, MD; Firooz Bassir, MD; Adnan Matta, MD; Pramote Tanswai, MD; Dhiti Tepkasetkul, MD; Prabhas Tungsangiumvisai, MD, and Damrong Wongchantara, MD, Southfield

Abstract

The effect on experimental renovascular hypertension by splenic artery and splenic pedicle implantation was studied in dogs. Out of 27 dogs subjected to right nephrectomy and partial ligation of the left renal artery, sustained hypertension was obtained in 10. Splenic artery implantation into the left kidney was performed in four of these hypertensive animals. Splenic pedicle implantation was carried out in three and the remaining animals were subjected to sham splenectomy. Revascularization of the ischemic kidney was best accomplished by splenic artery implantation. Blood pressure determinations as well as radiographic studies were used to determine the effect on the ischemic kidney.

In 1934 Goldblatt[1] produced experimental renovascular hypertension in the dog by unilateral nephrectomy and partial occlusion of the contralateral renal artery. Since this classic experiment the entire renin-angiotensin system has been clarified and at the present time all products described in this system have been isolated in the laboratory. Clinically, however, the treatment of renovascular hypertension remains a problem in many cases. Direct operative intervention on the renal artery lesion is proving not to be as successful as previously hoped for. In a recent publication by Stewart[2] nonoperative treatment is recommended for arteriosclerotic renal artery lesions unless the blood pressure cannot be controlled medically, while operative intervention is recommended for hypertension due to intimal, fibromuscular, medial and subadventitial hyperplasia of the renal artery. Renal parenchymal lesions such as nephrosclerosis, pyelonephritis and glomerulonephritis obviously would not be amendable to renal artery surgery, but possibly the blood supply to the parenchyma could be improved by direct revascularization.

Internal mammary implantation into the myocardium as first described by Vineberg[3] is now an accepted procedure in the treatment of myocardial ischemia, while implantation of splenic vessels into the kidney at the present time is still in the experimental stage. Davis[4] described the first splenic artery implantation in 1957 and Goldsmith[5,6] has reported his results with a splenic artery implantation for experimental hypertension. The effect of splenic pedicle implantation on renal function has been studied by Friedman.[7] The purpose of this paper is to study splenic artery and splenic pedicle implantation into the renal parenchyma and compare their effects on renovascular hypertension.

Methods

Twenty-seven adult mongrel dogs were used. Base line blood pressure determinations were obtained under light pentothal anesthesia by direct femoral artery puncture with a 19 gauge needle. The impulse was recorded on an E and M Physiograph — 6 recorder through a Narco Biosystems P-1000-A pressure transducer.

The hypertensive experimental model was then

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made by a method similar to that described by Najafi.[8] Under general anesthesia a midline incision was made, a right nephrectomy was carried out and the lumen of the left renal artery was compromised by placing a No. 4-0 arterial silk suture through the renal artery near the aortic junction and tying the suture so as to partially occlude the renal artery. Often a bruit could be palpated after the ligature had been completed. Weekly blood pressure readings were recorded until the animals became hypertensive.

Satisfactory hypertension of at least 180/110 mm Hg. which was sustained for at least one month was obtained in ten dogs. Three of these were subjected to splenic pedicle implantation, four underwent splenic artery implantation and a sham splenectomy was done in three animals for control *(Fig. 1).*

In the four dogs which underwent splenic artery implantation the abdomen was again opened through a mid-line incision under general anesthesia. A splenectomy was performed. The splenic artery was prepared by carefully dissecting this structure away from the vein and placing a vascular clamp near the junction of the splenic artery and pancreas. While the bleeding was being controlled, multiple perforations were made in the distal portion of the artery with an 18 gauge needle. The clamp was released and reapplied to assure adequate bleeding. The left kidney was then exposed and a tunnel was created parallel to its outer surface by forcing a large curved hemostat in the lower pole of the kidney parenchyma and tunnelling parallel to the lateral margin to exit through the upper pole. The end of the perforated artery was grasped by the hemostat, drawn through the tunnel and sutured to the renal capsule in the area of the lower pole.

In the splenic pedicle procedures a splenectomy was performed and the pedicle was prepared by dissecting the splenic artery and vein together, being careful not to distrub the capillary bed between these two structures. Arterial perforations were not made in the pedicle preparation. The renal implantation was done in an identical manner to that described for the splenic artery implantation.

Biweekly blood pressure determinations were made and recorded in all animals for eight weeks. An aortogram was carried out in an animal with a splenic artery implant. Post-mortem examinations were done in an animal with the arterial implant and an animal with the pedicle implant. The patency of the implanted vessels was confirmed by injecting the implanted splenic vessels with contrast material and exposing radiographs of the specimens.

Results

Out of the 27 dogs subjected to right

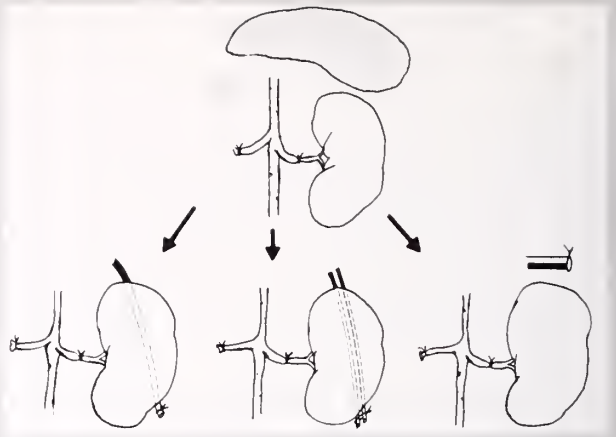

Fig. 1. Diagrammatic illustration of experimental model and the three experimental operations utilized; splenic artery implantation, splenic pedicle implantation and sham splenectomy.

nephrectomy and partial ligation of the left renal artery, 10 satisfactory hypertensive experimental models were obtained with a sustained blood pressure of at least 180/110 mm Hg. The criteria for sustained hypertension included at least three determinations at the above level over a period of at least one month.

Nine animals expired in the immediate postoperative period from various causes such as evisceration, hemorrhage and renal infarction. Satisfactory sustained hypertension was not obtained in eight animals and these were removed from the experiment. Of the 10 hypertensive animals, four underwent splenic artery implantation, three underwent splenic pedicle implantation and three underwent sham splenectomy.

A significant and sustained drop in blood pressure was obtained in the four dogs subjected to splenic artery implantation *(Fig. 2).* However, the time required to obtain this change varied from two weeks to five weeks. In two animals the blood

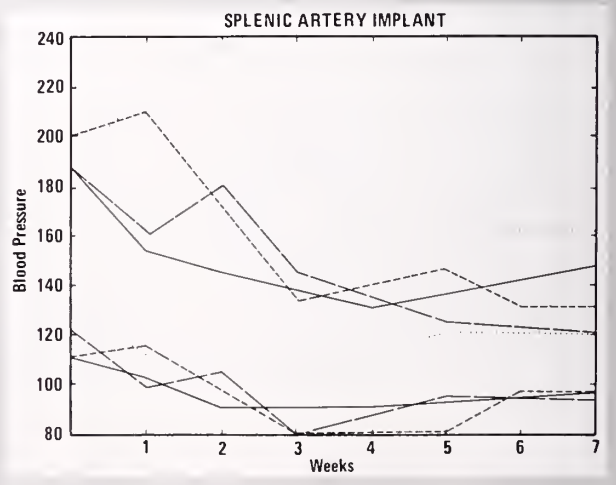

Fig. 2. Graphic representation of the effect of splenic artery implantation of renovascular hypertension.

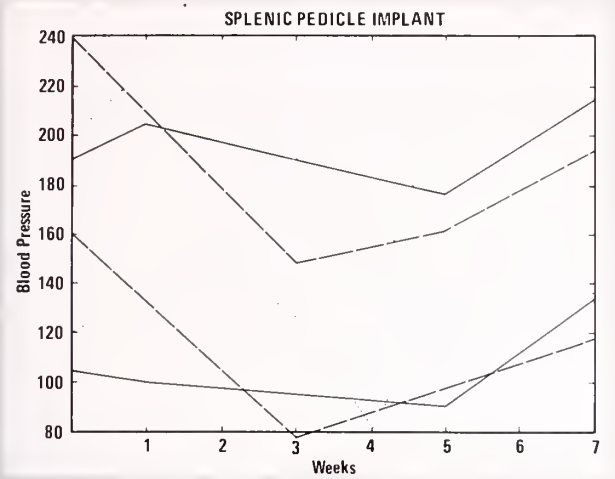

Fig. 3. Graphic representation of the effect of splenic pedicle implantation on renovascular hypertension.

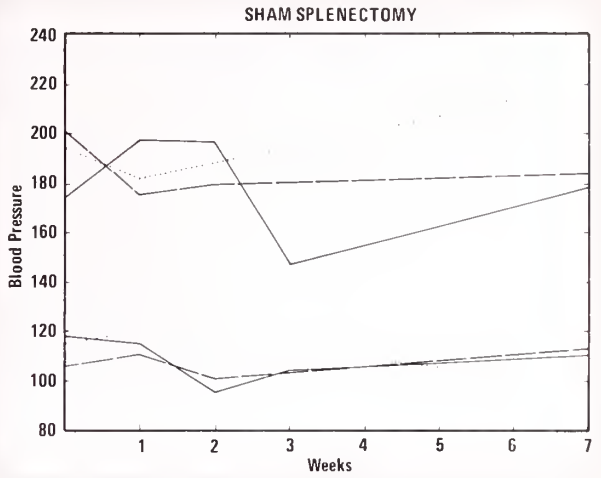

Fig. 4. Graphic representation of the effect of sham splenectomy on renovascular hypertension.

pressure stabilized at normotensive levels of 130/100 mm Hg. or less, their approximate base line levels. Some elevation of the diastolic blood pressure was evident in the remaining two animals.

Fig. 5. Aortogram demonstrating patent implanted splenic artery (arrow).

Constant results were not obtained by splenic pedicle implantation *(Fig. 3)*. No significant change in blood pressure was noted in one animal. In another animal with an extremely elevated initial blood pressure of 240/160 mm Hg. variable blood pressures from 160/98 mm Hg. to 204/120 mm Hg. were obtained. In the third animal a drop to 175/90 mm Hg. in one month was obtained.

No significant changes in blood pressure were noted in dogs which underwent sham splenectomy *(Fig. 4)*.

An aortogram which was performed in a dog subjected to a splenic artery implant demonstrated a patent splenic artery *(Fig. 5)*.

Post-mortem selective angiographic studies made by injecting contrast material solely into the implanted splenic artery demonstrated excellent collateral circulation in the splenic artery implantation specimen *(Fig. 6)*. However, only fair

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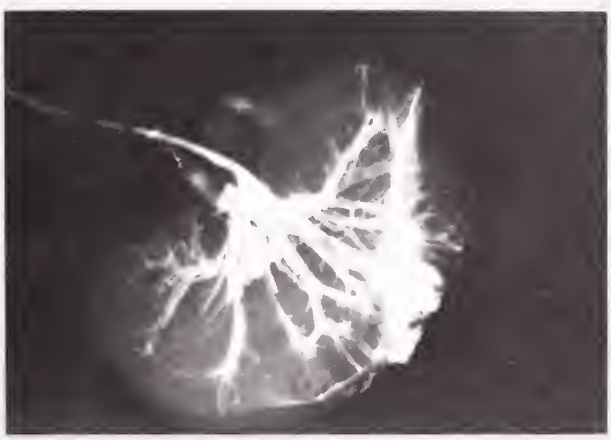

Fig. 6. Post-mortem radiograph of splenic artery preparation, made by injecting contrast material solely into implanted splenic artery, demonstrates excellent collateral circulation.

Fig. 7. Post-mortem radiograph of splenic pedicle preparation made by injecting contrast material solely into implanted splenic artery demonstrates only fair collateral circulation.

collateral circulation was observed in the splenic pedicle implantation specimen *(Fig. 7)*.

Discussion

Producing a satisfactory hypertensive experimental model proved to be more difficult than expected. Prior to this series we tried several techniques of applying a small Goldblatt clamp to the left renal artery and carrying out a right nephrectomy. The technique of Najafi[8] was also tried. Uniform results were not obtained with either method. However, improved results were obtained by placing a vascular suture through the left renal artery near the aortic junction and tying it so as to occlude 60 to 80 per cent of the lumen. A right nephrectomy is necessary if sustained hypertension is to be obtained regardless of the technique used to constrict the left renal artery.

The results of the implantation are similar to those obtained by Goldsmith[5,6] and Friedman.[7] However, a comparison of the effects of these two techniques on experimental hypertension has not been previously reported. The perforated splenic artery implantation results in a better collateral circulation as evidenced by the post-mortem radiograph. The arterial implant is much more effective than the pedicle implant in lowering experimental renal hypertension. Possibly the perforations in the splenic artery allow extensive migration of endothelial tissue which is necessary to collateral circulation.

One can only speculate on the clinical effectiveness of the above procedures. It is problematic if the circulation of an ischemic kidney could be improved by such an arterial implantation especially if the kidney is already involved with end artery disease. Vineberg[9] has stated that the incidence of occlusion of an artery implanted in the myocardium is much lower if the myocardium is ischemic than if it is normal. Nevertheless, producing collateral circulation in the kidney would not necessarily increase the glomerular and juxtaglomerular blood flow which would be necessary if the renin system were to be altered.

Summary

Twenty-seven dogs were subjected to right nephrectomy and partial suture ligation of the left renal artery in an effort to obtain a renovascular hypertensive model. Nine animals expired in the immediate post-operative period. Satisfactory experimental hypertension was obtained in 10 animals. Of these, four were treated by perforated splenic artery implant, three were treated by splenic pedicle implant and three were subjected to sham splenectomy. Perforated splenic artery implantation is more effective than splenic pedicle implantation in lowering experimental renovascular hypertension. Post-mortem angiographic studies demonstrate a more extensive collateral circulation in the kidney with the splenic artery implant than with the splenic pedicle implant.

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Intrahepatic Cholestasis in Hyperemesis Gravidarum:

A Case Report

By Peter A. Marks, MD; Lloyd A. Kammeraad, MD, FACOG, and John P. Papp, MD, FACP, Grand Rapids

Abstract

A case of intrahepatic cholestasis associated with hyperemesis gravidarum is reported. The intrahepatic cholestasis was demonstrated on histologic examination of a liver biopsy specimen. In a review of the English literature, no previous report was found demonstrating alterations of liver histology. The mechanism for the cholestasis is obscure.

Hyperemesis gravidarum is defined as vomiting occurring in pregnancy before the 20th week of gestation of such severity as to require hospitalization.[1] It is not associated with coincidental conditions which might cause vomiting. In a review of the English literature, only one report by Adams, Gordon and Combes[2] describing four normal liver biopsies in four patients with hyperemesis gravidarum and elevated bilirubin levels was found. This report describes a jaundiced woman with histologically demonstrated intrahepatic cholestasis and hyperemesis gravidarum.

Case Report

A 26 year-old white gravida 3 para 3 woman was admitted to Blodgett Memorial Hospital in January, 1972, at 10 weeks' gestation because of persistent vomiting of three weeks' duration. Serum electrolytes and a SMA-12 were normal except for a total bilirubin of 1.25 mg per 100 ml. The serum glutamic oxalacetic transaminase (SGOT) was 27 and the alkaline phosphatase 65 SMA units. The patient received intravenous fluids and was discharged four days later. She had not received phenothiazine medication prior to nor during the hospitalization.

Because of persistent vomiting, she was readmitted two weeks later and treated with intravenous fluids. She had received prochlorperazine 10 mg four times a day for several days prior to admission. Pruritus was never a complaint. Admission laboratory values revealed a total bilirubin of 3.6 mg with a direct of 2.8 mg per 100 ml. The SGOT was 114, the lactic dehydrogenase 150, and the alkaline phosphatase 95 SMA units. The serum glutamic pyruvic transaminase (SGPT) was 118 units. The 5' nucleotidase was 0.5 units (normal 0-1.6). The prothrombin time was 17.8 seconds (control 12.5 seconds). Counter electrophoresis for Australian antigen was negative. Serum protein electrophoresis was normal. Serum immunoelectrophoresis showed normal IgG and IgA values, but IgM was 420 mg per 100 ml (normal 40-200). The hematocrit and hemoglobin was initially 51 per cent and 17.2 g per 100 ml, respectively. After fluid replacement, the hematocrit was 39 per cent and the hemoglobin 12.4 g per 100 ml. The white cell count was 6300 with 70 per cent neutrophils, 23 per cent lymphocytes, 6 per cent monocytes and 1 per cent eosinophils.

The patient received intravenous fluid replacement, Trisogel[RX] and triflupromazine during her

(Continued)

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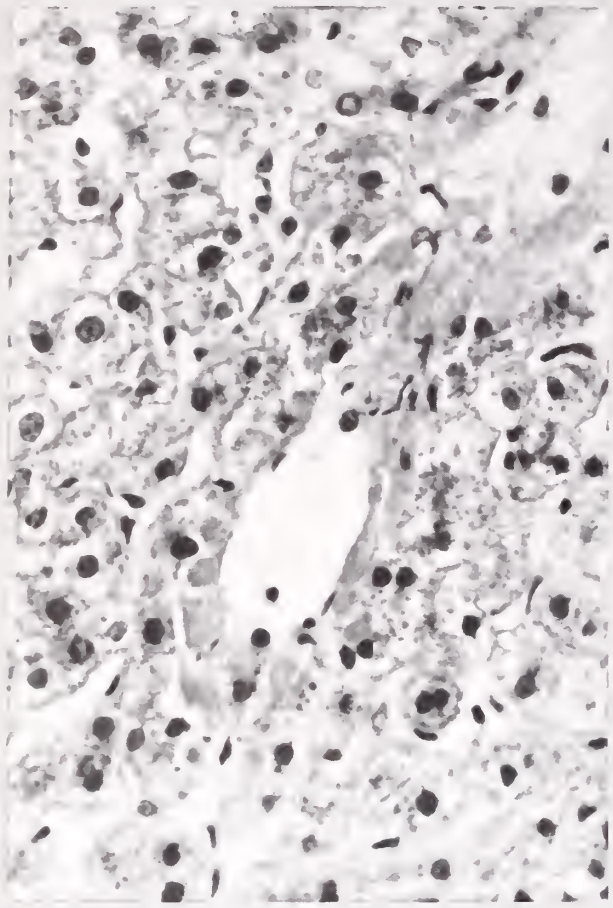

Fig. 1. Prominent intrahepatic bile pigment and bile "plugs" are seen surrounding a central vein. (x544)

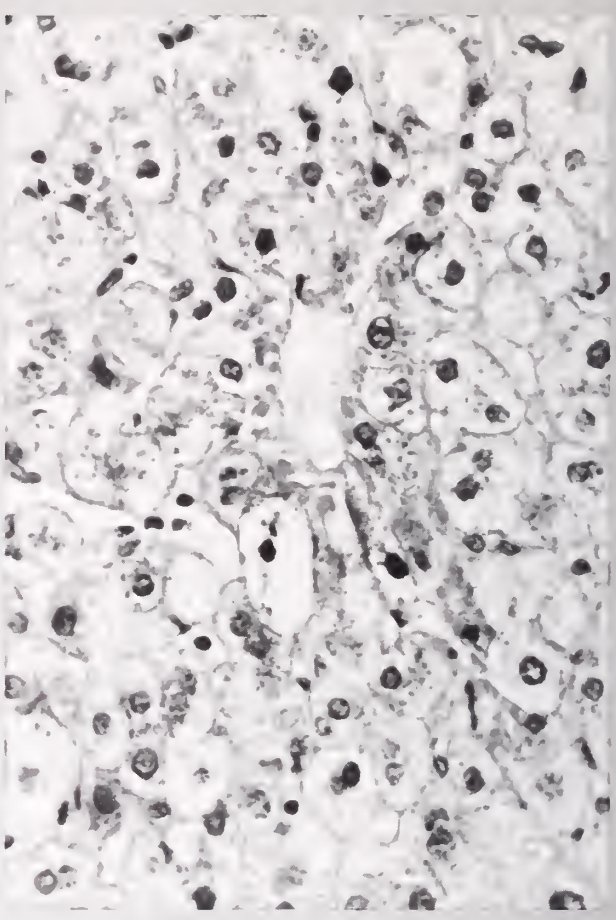

Fig. 2. Feathery degeneration is shown in several hepatocytes. A granular stippling reflects intrahepatic bile pigment. An occasional bile "plug" is seen. (x544)

two week hospitalization. A percutaneous liver biopsy was performed without difficulty. Histological examination revealed intrahepatic cholestasis primarily in the centrilobular areas and feathery degenerations of some hepatocytes. *(Figures 1 and 2).* The portal triads were normal. There was no dilatation of bile ductules. Numerous bile "plugs" were seen in some areas. No inflammatory infiltrate was seen in liver lobules nor portal triads. Upon discharge, all the abnormal liver determinations had reverted to normal.

After an uneventful second and third trimester, the patient was admitted at 44 weeks' gestation. Fetal heart tones were heard four hours prior to admission, but not at admission. After a short labor, she delivered a 4.2 kilogram stillborn female infant. Necropsy findings were compatible with the clinical syndrome of post-maturity.

Discussion

It is clear that our patient had hyperemesis gravidarum. The question to be answered in this report is whether the intrahepatic cholestasis found on liver biopsy examination was due to prochlorperazine or due to hyperemesis gravidarum.

Sensitivity-type cholestasis due to phenothiazine drugs is well recognized. The onset of illness may simulate viral hepatitis with anorexia, jaundice and pruritus. An eosinophilia may be seen in peripheral blood films in the early stages and later leukopenia. Light microscopy shows intracellular cholestasis, a marked cellular reaction in the portal zones with mononuclear and eosinophilic cells being prominent. "Feathery" degeneration may also be seen. Since 1958, several reports of cholestatic jaundice due to prochlorperazine have been reported.[4-6]

Hyperemesis gravidarum and intrahepatic cholestasis has been reported in the English literature[2,3,7] with elevation of serum bilirubin and transaminases. However, the only liver biopsies during the cholestasis have been reported as normal.[2]

Our patient had an elevation of her bilirubin prior to receiving prochlorperazine. She never experienced pruritus. Peripheral eosinophilia was never demonstrated. There was no portal triad in-

filtration of mononuclear nor eosinophilic cells on liver biopsy examination. For these reasons, we feel that the demonstrated intrahepatic cholestasis probably was associated with hyperemesis gravidarum and not drug induced. It is interesting that the abnormal liver parameters resolved with treatment of her hyperemesis despite the administrations of another phenothiazine drug, triflupromazine. The etiology of the intrahepatic cholestasis associated with hyperemesis gravidarum remains obscure.

Summary

A multiparous first trimester gravid woman with hyperemesis gravidarum and intrahepatic cholestasis is reported. The etiology of the cholestasis remains unclear. The cholestasis was not felt to represent a hypersensitivity hepatic reaction to prochlorperazine. Previous liver biopsies have been reported as normal in the English literature.

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MICHIGAN DEPARTMENT OF PUBLIC HEALTH

Monthly Surveillance Report

Cases of Certain Diseases
Reported to the Michigan Department of Public Health
For the five-week period ending May 31, 1974

	1974 This 5-Week Period	1973 Same 5-Week Period	1974 Total To Above Date	1973 Total Same Date	Total Cases for 1973
Rubella	237	474	885	1,387	2,001
Cong. Rubella Syndrome	0	0	0	1	4
Measles	358	1,118	1,561	3,394	4,552
Whooping Cough	5	5	20	34	86
Diphtheria	0	0	0	0	0
Mumps	840	714	4,296	3,318	5,042
Scarlet Fever & Strep Sore Throat	3,371	2,199	22,076	11,784	24,467
Tetanus	0	0	1	0	2
Poliomyelitis (paralytic)	0	0	0	0	0
Hepatitis	315	381	1,674	1,694	3,872
Salmonellosis (other than S. typhi)	81	52	460	250	795
Typhoid Fever (S. typhi)	0	3	2	6	14
Shigellosis	95	66	422	237	623
Aseptic Meningitis	5	10	48	58	434
Encephalitis	5	20	24	64	163
Meningococcic Meningitis	8	8	27	26	54
H. Influenza Meningitis	8	14	54	52	89
Tuberculosis	158	169	586	711	1,380
Syphilis	220	447	1,303	1,907	4,328
Gonorrhea	2,891	2,424	13,116	11,683	31,128

Information can be supplied by the local health department on the local incidence of disease.

Maurice S. Reizen, MD, Director
Michigan Department of Public Health

Doctor Abbasi Gains New Laurels in Medical Photography Competition

Ali A. Abbasi, MD, of Allen Park, has been awarded first prize in the medical photography division of the 1974 SAMA-Eaton Medical Art Award Competition, adding to the series of awards he has been taking in the competition since 1968.

Doctor Abbasi's prize winning photo, "Tophaceous Gouty Arthritis of the Hand," was published in the May 13 issue of *JAMA*. He received an honorable mention award for another photograph, "Hyperextensibility of Joints in the Ehlers-Danlos Syndrome."

The awards competition is sponsored by the Student American Medical Association and Eaton Laboratories to stimulate the use of graphics in medical communications. A SAMA-Eaton Medical Art Gallery is now being assembled for display at medical conventions throughout the country.

Doctor Abbasi is chief of endocrinology and metabolism at the Veterans Administration Hospital in Allen Park and is assistant professor of medicine at the Wayne State University School of Medicine. Here are some samples of his medical photography. All have been SAMA-Eaton award winners.

Doctor Abbasi took the above photo, "Unusual Intraorbital Puffiness in a Myxedematous White Female" with his Nikon camera; Ektachrome, f16, 1/60 sec., electronic flash, close-up lens #2.

Onycholysis (Plummer's Nails) in a Black Female with Graves Disease.

Argyria in 70-year-old Woman.

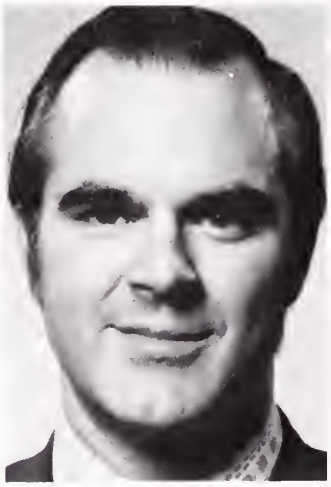
Ainhum (Dactylolysis Spontanea) in a Middle-Aged Black Female; Nikon camera, Ektachrome, 1/60 sec.

Commentary

Discriminatory Payment Practices:

A Stringent Barrier to Quality Rural Medicine

By Raymond L. Hockstad, MD, Escanaba
Member, MSMS Council



Dr. Hockstad

The Upper Peninsula has a distinct problem as do most rural areas throughout the state of Michigan in providing its citizens, our patients, with adequate medical services. The problem is our short supply of physicians and concurrently our short supply of modern sophisticated medical equipment and facilities. This problem is propagated by a stringent barrier to securing new physicians for rural areas arbitrarily forced on us by the federal government, state government and prepaid insurance companies.

First, I do not think there is any argument that rural areas are short of physicians, but for the record I would like to supply the latest figures developed by the Michigan State University Allied Health Manpower Bureau in relation to the Upper Peninsula. The Upper Peninsula has one physician per 1,470 people where the national average is one to approximately 700 people. The Escanaba area has one physician to 1,800; the St. Ignace area, one physician to 1,900; Sault Ste. Marie, one physician to 1,400 people. Only Marquette, which has developed a specialist referral center, and Iron Mountain, which has a large Veterans Administration Hospital, are below the one to 1,000 level and they still do not approach the national average. Thus without argument the Upper Peninsula has a shortage of physicians.

Michigan Medicine's new Commentary page will offer physicians and others the opportunity to express opinions on issues in medicine. Contributions are invited and should be submitted to Commentary, *Michigan Medicine,* 120 W. Saginaw St., East Lansing, Mich. 48823.

The views expressed here are those of the author and do not represent positions of the Michigan State Medical Society or opinions of the editors of *Michigan Medicine.*

Barrier to Recruitment

Now there may be some that would argue that there is, indeed, existing a barrier to recruiting new physicians, but again let's let the facts speak for themselves. Today there are 230 licensed physicians in the Upper Peninsula as compared to 217 10 years ago. This represents a growth of 6 per cent. The remainder of Michigan has shown a growth over the same 10 year period from 7,746 physicians to 9,436 physicians, a growth of 22.2 per cent. Furthermore all of the U.P.'s growth has been as the specialists have moved into the Marquette area, and this area has grown from 45 to 70 physicians. Thus the rest of the U.P. has actually lost physicians.

I have said now, first, that we have a shortage of physicians in rural areas and that is a fact. Secondly, I have stated that there is a barrier to recruitment of physicians in the Upper Peninsula

and have shown that, indeed, there does seem to be such a barrier. I have also stated that the barrier itself comes from the federal government, state government and large prepaid insurance companies and will now show you in what way these agencies create a barrier.

There is currently in existence in Michigan a terribly discriminatory, archaic method of payment for medical services. This archaic method adversely effects the quality of available medical care in rural areas and specifically in the U.P. This archaic payment practice very simply is the federal government's, the state government's and large insurance companies' payment of a larger fee for the same service to an identical physician in a large metropolitan area than in a rural area, often as high as 60 per cent more. That is, equally competent, equally trained physicians are paid not on the basis of training, knowledge, experience or ability but solely on the basis of where each lives in the state. If he lives in a large metropolitan area he is paid more than if he lives in a rural area.

Larger Reimbursement

This larger reimbursement in the metropolitan areas for equal medical services encourages new physicians to locate their new practices in these metropolitan areas which already have an adequate number of physicians and concurrently encourages the further development of superspecialization and of expensive, sophisticated medical equipment and facilities in areas that already have them. This reimbursement practice discourages the establishment of new practices and concurrently new facilities and equipment in rural areas.

This discriminatory arbitrary unequal payment practice solely based on where the service is given is the stringent barrier to improving medical care in rural areas.

This discriminatory barrier must be broken down. There is just no logical basis for retaining this archaic payment practice. Those that have often defended this archaic practice have made such eloquent comments as:

(1) The cost of living is greater in metropolitan areas than in the Upper Peninsula.

(2) The cost of running a medical practice is greater in a metropolitan area than in the Upper Peninsula.

(3) Rural areas always charge lower fees for medical services and should be expected to continue to.

Nonsense, all of it!

Let's take the reasons one by one and see.

First, the cost of living as shown in the latest economic survey is not greater in the metropolitan areas than in the rural areas but quite the contrary. Recent studies have actually showed it costs more to live in the Upper Peninsula.

Second, until a 1971 medical society study was completed entitled "Trends and Overhead Costs of Medical Practice," I too swallowed the malarky precipitated by the hierarchy that in large metropolitan areas it costs more to run a practice than in rural areas. This study, and a more recent study, showed that the ratio between costs and revenue for physicians is similar in the Upper Peninsula and the Detroit area.

Third, the argument that rural areas should receive less for services as services were always less seems redundant in the light of the above two facts. There is no question payment for services based on economic requirements should be at least the same in rural areas as in the metropolitan areas. But they are not, why? Well, it is true, charges for services used to be less in rural areas, but that is in the past. Why were they lower? Local areas nationwide used to support and pay for only what their local economic situation could

(Continued on Page 412)

Education

Dean Comments on Issues in Retention of Michigan Medical Graduates

By Andrew D. Hunt, MD, Dean, College of Human Medicine
Michigan State University

The problem of retention of medical graduates in Michigan has been given much attention and thought in the College of Human Medicine, as well as in the Council of Deans for the Michigan Medical Schools, which includes the Dean of the College of Osteopathic Medicine at Michigan State University.

Likewise, the Office of Health and Medical Affairs, within the office of the governor, together with its State Health Planning Advisory Council, is about to embark on a health manpower study which will surely focus in depth on this issue.

Adequate Numbers

The ultimate goal, so far as physician manpower is concerned, is an adequate number and distribution of physicians throughout the state of Michigan to meet the state's health care needs. This assumes, of course, not only adequacy of numbers, but appropriateness of specialty and expertise to insure a balanced corps of physicians. Thus, over the last decade, there has been a serious drop in the percentage of physicians in general practice or, as it is now called, family medicine. This development needs immediate correction, and steps are underway to accomplish this. It should, however, be recognized that in expanding training programs and opportunities in family practice, the continued need for specialists, though perhaps at a more moderate rate, must not be overlooked.

However, I will limit myself to the issue of retention of the graduates of medical schools.

In general, the three allopathic medical schools in the state retain about 50 per cent of their graduates at the level of internship. Classes at Michigan State, of which we have had three so far, have been of such small numbers that the statistics are probably not valid. Of the class graduating this year, of which there are 55, approximately 50 per cent will stay in Michigan for internships.

Studies Underway

Data on what happens to these graduates who leave the state after their internships (the number who return to Michigan and eventually to practice) are not available. Nor do we have comparable data on the ultimate place of residence of those who stay in Michigan for their internships. Work is being done on this subject by a group at the University of Michigan, and as the data become more refined they will be made available.

Meanwhile, we can assume that the primary task is to retain a higher per cent of graduates of Michigan medical schools in internships in Michigan hospitals. This problem, incidentally, is largely limited to the allopathic schools. The College of Osteopathic Medicine appears to have a higher retention rate, due to the fact that a very high per cent of the total opportunities nationally for internships in osteopathic hospitals is located in Michigan.

What then, are the problems to be overcome? One which is commonly mentioned; namely, climate, we can do nothing about. We must recognize that California and Florida, whose retention rate is high, can attribute some of their success to meteorological happenstance. Minnesota and Indiana, however, are also doing well, and there is no reason to think we cannot significantly improve our record in this state.

The situation, then, in the allopathic scene in Michigan, essentially is as follows:

1. *The hospitals.* Except for the situation in a few hospitals either owned or controlled by medical schools, essentially limited to Detroit and Ann Arbor, internships and residencies are hospital-based and financed and operated by the hospitals, with money largely coming from patient care income. While university affiliation is becoming very desirable not only in starting new internships and residencies, but in maintaining existing ones, the absolute need for such university

affiliation has not yet become national policy, and there is doubt in many people's minds that it will. Thus, a significant variable in the entire process has to do with hospital policies in selecting their interns.

2. *Schools of medicine.* Medical schools in the past have tended to nurture students with interest in specialities, and thus have tended to advise as many students as possible to try for the high prestige university hospitals. Since the number of such places is limited in Michigan, quite naturally students must go elsewhere to find them. There is a rather marked change in medical school attitudes in this direction, medical schools tend not only to be developing family practice programs, but helping hospitals to do the same, and medical faculty nurturing of students with family medicine as a goal is becoming far more usual. Certainly in the College of Human Medicine at Michigan State, such nurturing is, so far as such policy can be established, the policy of the institution.

3. *The students.* It must be understood that medical students, by the time they receive their MD degrees, have become essentially free agents. Internships are awarded by a national program known as the National Internship and Residency Matching Plan by which students, in the fall, on a national basis, list their first, second, thrid, etc., choices of internships. The hospitals, likewise, having received lists of students interested in their programs, list the students they wish in order of priority. On a certain day in April, both hospitals and students see the printout indicating how they have "matched." The great majority of students are placed in internships by this program. Those who have not been "matched" are placed through negotiations. Input of the medical school to this process is largely through student advising, with little or no control over the choice being made by students themselves. Nor, for that matter, do the medical schools have any authority over the way the great majority of hospital internship directors make their selections.

How then do we modify this complex system so as to keep more graduates in Michigan? Such modification would involve input from interested legislators, the executive office, medical schools, the state medical society, county societies offering programs in medical education, the Michigan Hospital Association and the state chapters of the various medical specialty societies, including the Academy of Family Physicians, and probably others as well. Attention needs to be given to the following considerations:

1. *Internship and residency programs.* Directors of hospital-based graduate training programs should be urged to give a high recruitment priority to graduates of Michigan medical schools (or Michigan residents obtaining undergraduate education in medical schools in other states). It is often a temptation for directors of such programs to lean toward graduates of highly prestigious ivy league institutions, since it is desirable for an internship and residency staff to have a variety of educational backgrounds. These attitudes need to be dealt with openly and honestly with the hope that the higher priority of the state's needs to retain its own graduates can be generally adopted.

The problem of the foreign medical graduate, of course, needs to be dealt with as well, and it is most difficult. It is possible that the national effort to require all applicants for American internships to have passed the National Board Examinations or the FLEX examinations (e.g., Michigan State Board Examinations) would help with this problem.

2. *The medical schools.* Medical school faculties involved in student advising should be encouraged to emphasize the opportunities available in Michigan hospitals. In this connection there is a great tendency among both full-time faculty and voluntary faculty (who, as practicing physicians are very much involved in the education of our students) to take primary interest in the students'

(Continued)

own personal and developmental needs. Thus, in the eyes of many faculty, a student who has been born, brought up and totally educated in Michigan can profit greatly by seeing other parts of the country before making up his mind where to settle.

3. *The students.* Medicine is almost unique as a profession in that immediately upon graduation a $10,000 internship is available in almost any part of the country. Again, the desirability of "seeing the country" before making a final decision is a significant factor which must be realistically dealt with in any concerted effort.

4. *State government.* Government is limited in what it can accomplish, especially in view of the strong constitutional questions engendered by programs implying indentured service.

However, it is probable that the future will see increasing financial support of internships and residencies by state government, as the third party payment mechanism for such support becomes less feasible. It seems quite appropriate for such subsidies to be accompanied by requirements for high priority on graduates of Michigan medical schools. Such inducements as low interest loans to start practices in the state, etc., could also be developed.

I would be inclined to suggest preliminary meeting of a group such as that mentioned previously to begin thinking about a statewide effort to improve the situation concerning retention of physicians in the state. I think there is enough good will among the interested parties and concern about the problem to justify the time spent on such an effort.

Lenawee Physicians to Aid Students

The Lenawee County Medical Society has voted to provide scholarship assistance to medical students from the county. William Gilkey, MD, county society president, said a committee would be appointed to conduct the assistance program for students and to encourage them to return to Lenawee County to practice after completing training. The amount of scholarship aid to be available was not set.

Sports Conference Carries Credit

Physicians who attended the 1974 Michigan Conference on the Medical Aspects of Organized Athletics, held April 11 at Grand Valley State Colleges, Allendale, qualified for seven prescribed hours of credit in the American Academy of Family Physicians. For certification of attendance, write: Helen A. Schulte, Michigan State Medical Society, PO Box 950, East Lansing, Mich. 48823.

U-M Lists Courses for Coming Year

Following is the list of postgraduate courses currently planned for 1974-75 by the University of Michigan Medical Center. Additions to the schedule are expected later. All Courses will be held at Towsley Center in Ann Arbor, with the exception of the Northern Michigan Summer Course.

Sept. 24-26	Blood Coagulation Techniques
Oct. 2	Illness in Children (for Social Workers)
Oct. 8-10	Cardiology for Internists
Nov. 8-9	Advanced Burn Care
Nov. 13	Medicine and Law: Trends and Protections
Nov. 15-16	Anesthesiology Conference
Dec. 4	Cardiology for Family Physicians (MAFP)*
Dec. 6	Basic Burn Care
1975	
Jan. 10-11	Respiratory Therapy Conference (MSRT)*
Jan. 20-24	Family Practice Review (MAFP)*
Feb. 18-20	EKG Diagnosis
Feb. 25-28	Emergency Medicine (ACEP)*
March 5-6	Advances in Pediatrics
March 7	Basic Burn Care
March 10-11	Surgical Complications: Prevention and Management
March 18-20	Morphology
March 31—April 2	OB-GYN Conference
April 16	Orthopedics in Family Practice (MAFP)*
April 17-18	Medical Technology/ Hematology
May 1-2	Ophthalmology Conference
May 13-14	Therapeutics (MAFP)*
June 3-6	Advances in Internal Medicine
June 11-12	Sexual Problems in Family Practice
June 23-27	Northern Michigan Summer Course

Additional information about the courses is available from Robert Richards, Towsley Center for Continuing Medical Education, Ann Arbor, Mich. 48104.

*Co-sponsored with the following organizations:
MAFP—Michigan Academy of Family Physicians
MSRT—Michigan Society of Respiratory Therapists
ACEP—American College of Emergency Physicians

Emergency Physicians Serve Northern Towns

Can a visitor to northern Michigan expect to find quality emergency medical care should it be needed?

At least 15 communities scattered throughout the upper part of the state can answer in the affirmative thanks to three enterprising young physicians.

The three, Robert M. Williams, MD, of Grayling; James M. Johnson, MD, of Traverse City, and Q. Michael Ditmore, MD, of Alpena, recognized a need and set out to meet it. They formed a corporation, Northern Professional Emergency Physicians, PC, in 1970 and have been watching a steady growth ever since.

Doctor Williams is president of the corporation, Doctor Ditmore, secretary and Doctor Johnson, treasurer. All are under 35 and received their medical degrees within the last five years.

The corporation has contracts to provide emergency department care at hospitals in Alpena, Cadillac, Charlevoix, Gaylord, Gladwin, Grayling, Iron Mountain, Ludington, Marquette, Rogers City, Sault Ste. Marie, Tawas City and West Branch as well as three cities in Wisconsin.

Unique Features

One of the unique features of the operation is the tailoring of the contract to the needs of the individual hospital. Emergency needs of the hospital are studied. Some hospitals want seven-day, 24-hour coverage while others want only 24-hour weekend care. Some want coverage only during the summer when tourism is at its peak and there is a need to ease the load on the regular staff physicians. "We try to tailor an individual contract to give exactly what the hospital desires," Doctor Williams told *Michigan Medicine.*

After determining a hospital's needs, the corporation works through the medical staff for acceptance of the idea. The corporation's experience has been that once its service is known, emergency department visits increase about 50 per cent. "Staff doctors are generally receptive to the idea," Doctor Williams reported, "because it gives them assurance of coverage during vacation periods, more weekend freedom, some protection from abandonment charges and in many cases, referrals and follow-up care."

Hospital boards must approve features. In most instances the hospital's subsidizing costs are relatively low. Most contracts are completely self-supporting within three years, Doctor Williams indicated.

Civic Involvement

Meetings are held with civic, business and industrial leaders in the area to explain the service and its benefits to the potential consumers, public educational programs on how to use the ER (including an explanation of insurance payment policies) are conducted and 60 hours of training for the ambulance attendants are sponsored. Coordination of a local disaster plan and work toward establishment of a regular emergency department where none exists also are initial activities.

After a contract is signed the hospital is guaranteed qualified physician coverage during specified hours. The corporation assumes the task of providing the physician manpower needed.

Doctor Williams emphasized that the corporation offers no in-patient services other than response to critical or life-threatening situations within the hospital during hours ER staff is present. All follow-up care is referrred to the patient's personal physician.

During 1973, corporation physicians handled more than 28,000 cases and with hospitals added in 1974 expect to serve some 75,000 patients this year. Doctor Williams said he expects the corporation to bill more than 100,000 cases a year.

Physicians Recruited

Obviously three doctors cannot handle this work load. The three principals work regular duty shifts in their own communities and try to spend some time on a rotating basis in each of the hospitals they are responsible for staffing, but they depend heavily on their massive recruiting techniques to attract the needed physicians.

Doctor Williams, who handles the major responsibilities for staff recruiting, recently sent out more than 3,000 letters to medical schools, hospitals, clinics and medical groups all over the country advertising for ER physicians. An average day brings seven to ten inquiries from interested doctors.

Unique too about the operation is that a doctor may work for the corporation for a week, a month or two, a summer or longer. "We have one medical school professor who comes up for a month's vacation with his family and signs on for a solid week of ER duty to help finance his vacation," said Doctor Williams.

(Continued)

All doctors employed by the corporation are screened for proper credentials, Michigan licensing and medical experience, especially in trauma.

"We lean toward doctors who already have ER experience either through a formal residency or through regular emergency medicine duty in their respective hospitals," Doctor Williams stated. He noted that they tend to employ primarily family practitioners, internists and surgeons (general and orthopedic) as opposed to other specialists because these are the physicians who most frequently work emergency rooms.

Membership in the American College of Emergency Physicians is strongly recommended for doctors seeking corporation employment and is mandatory for any full-time employees. Full-time means 56 hours per week in some type of rotation.

From Many States

Last year the corporation employed doctors from Harvard, Johns Hopkins, USC, UCLA, Mayo Clinic and other prominent medical schools as well as from states as scattered as Texas, Indiana, Florida and Oregon.

One of the benefits of the entire operation is the exposure which the smaller communities get.

"We know of at least two doctors who liked the area so well they decided to remain and establish local practices," Doctor Williams explained.

"It has been our experience that some patients from larger cities in Michigan and other states are pleasantly surprised to find good quality emergency care in these smaller, isolated communities. They in turn tell friends at home about their experiences and encourage those who might not have ventured into some of these areas to do so.

"At the risk of sounding like a local chamber of commerce tourist bureau," Doctor Williams said, "people can get gas to get to northern Michigan and they can get medical care if they need it."

INFORMATION FOR CONTRIBUTORS

1. Address scientific manuscripts to the Publication Committee, Michigan State Medical Society, 120 W Saginaw St., East Lansing, Mich. 48823. Submit original, double-spaced typewritten copy and two carbon copies or photo copies on letter size (8½ x 11 inch) paper. On page one, include title, authors, degrees, academic titles and any institutional or other credits.

2. Authors are responsible for all statements, methods and conclusions. These may or may not be in harmony with the views of the editorial staff. It is hoped that authors may have as wide a latitude as space available and general policy will permit. The Publication Committee expressly reserves the right to alter or reject any manuscript, or any contribution, whether solicited or not.

3 Illustrations should be submitted in the form of glossy prints or original sketches from which reproductions will be made by *Michigan Medicine*.

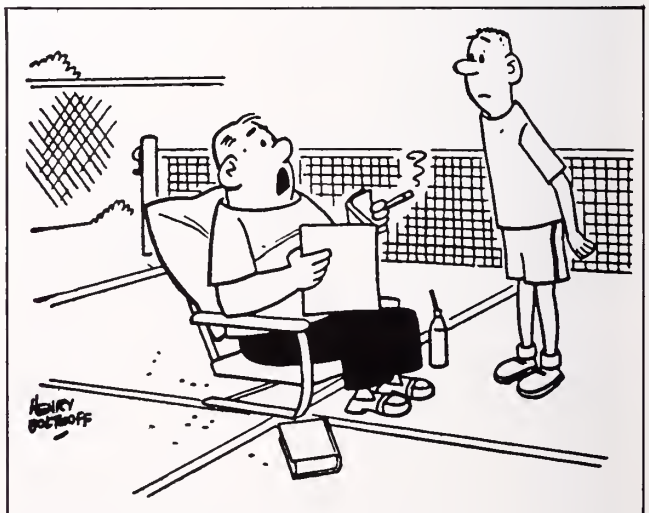
4. Articles should ordinarily be less than four printed pages in length (3000 words).

5. References should conform to *Index Medicus*, including, in order: Author, title, journal, volume number, page and year. Book references should include editors, edition, publisher and place of publication, as well.

6. The editors welcome, and will consider for publication, letters containing information of interest to Michigan physicians, or presenting constructive comment on current controversial issues. News items and notes are welcome.

7. It is understood that material is submitted for exclusive publication in *Michigan Medicine*.

8. Letters and articles for the news section should be sent to the Managing Editor, *Michigan Medicine*, 120 W. Saginaw St., East Lansing, Mich. 48823, by the fifth of the month preceding the month of publication.



"My doctor told me to spend three hours a week on the tennis court."

Integument!

Our skin—the human integument—covers us, defines us, protects us. But skin is subject to cuts, burns, abrasions. And infections. Neosporin Ointment fights infection by providing broad antibacterial action against susceptible skin invaders. It contains antibiotics that are rarely used systemically, reducing the risk of sensitization.

INDICATIONS: *Therapeutically*, used as an adjunct to appropriate systemic therapy for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

PRECAUTION: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Complete literature available on request from Professional Services Dept. PML.

NEOSPORIN® Ointment

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Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg. (equivalent to 3.5 mg. neomycin base); special white petrolatum q.s. In tubes of 1 oz. and ½ oz. and 1/32 oz. (approx.) foil packets.

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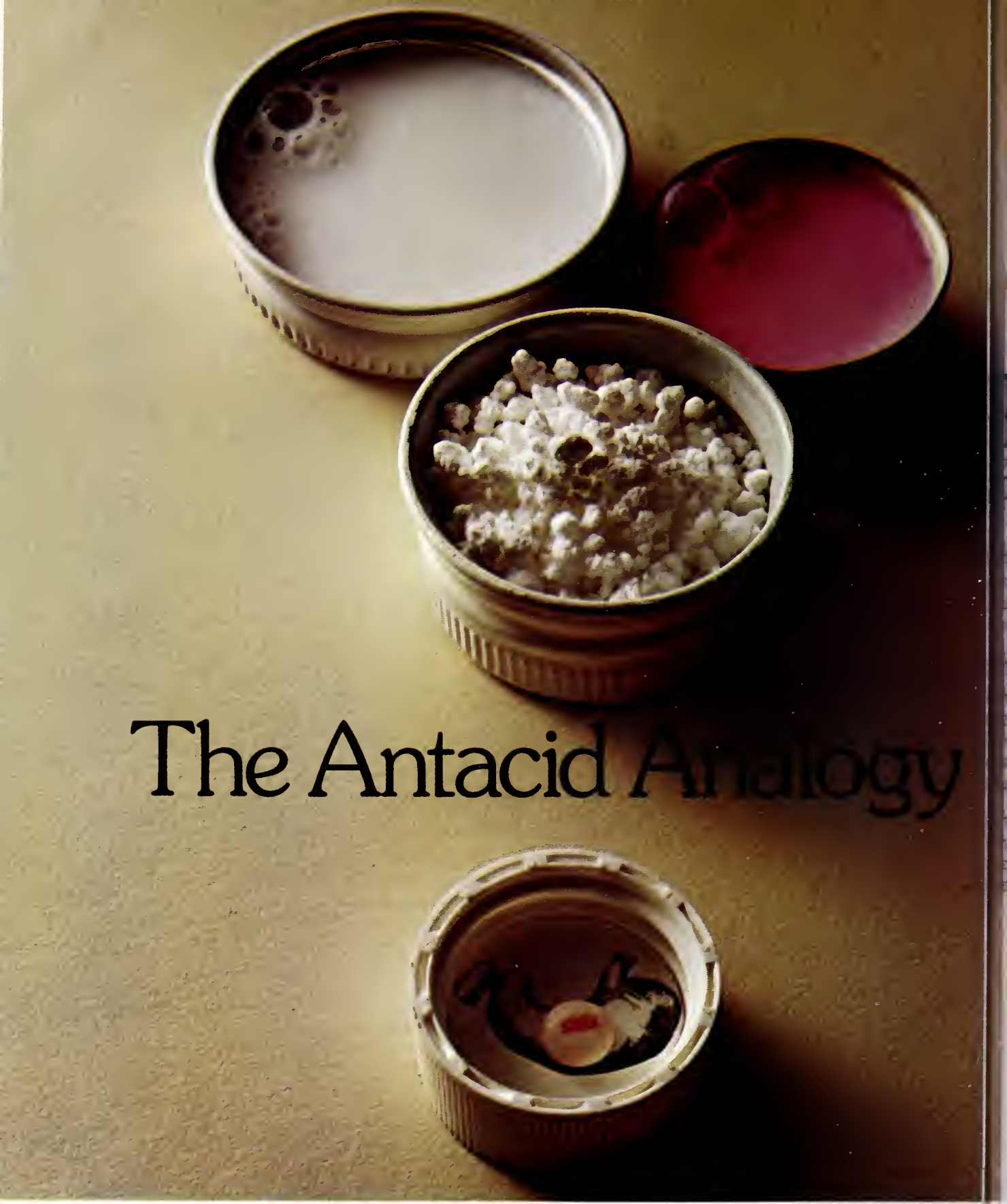

Indications: Pro-Banthine is effective as adjunctive therapy in the treatment of peptic ulcer. Dosage must be adjusted to the individual.

Contraindications: Glaucoma, obstructive disease of the gastrointestinal tract, obstructive uropathy, intestinal atony, toxic megacolon, hiatal hernia associated with reflux esophagitis, or unstable cardiovascular adjustment in acute hemorrhage.

Warnings: Patients with severe cardiac disease should be given this medication with caution.

Fever and possibly heat stroke may occur due to anhidrosis.

In theory a curare-like action may occur, with loss of voluntary muscle control. For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted.

Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthine.

Precautions: Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions may

Therapeutic comparisons in peptic ulcer.

Antacids have only one mode of action to relieve ulcer pain...

Pro-Banthine® has four.

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propantheline bromide

Antacids:

Antacids relieve ulcer pain by neutralizing gastric acid. This action is relatively short-lived and they have no other mode of action.

Pro-Banthine:

Pro-Banthine suppresses gastric acid secretion. The antisecretory properties of Pro-Banthine are well established. By effectively blocking vagotonic impulses Pro-Banthine suppresses gastric secretion to reduce both total and free acid.

Pro-Banthine helps relieve pain. Pro-Banthine relieves ulcer pain by reducing gastric secretion and the motility and spasm of the gastrointestinal tract.

Pro-Banthine reduces acidity without subsequent acid rebound. The capacity of Pro-Banthine to reduce the secretion of total and free acid in the stomach has been demonstrated in scores of studies. None has demonstrated any significant evidence of acid rebound.

Pro-Banthine activity lasts about six hours. The effect of a single therapeutic dose (15 mg.) of Pro-Banthine lasts about six hours.* Pro-Banthine P.A.®, the prolonged-acting form, is active from 8 to 12 hours. Thus Pro-Banthine may be used to suppress acid, spasm, and pain around the clock, even during the sleeping hours when antacids, to be effective, must be taken almost hourly.

*Innes, I. R., and Nickerson, M., in Goodman, L. S., and Gilman, A. (editors): The Pharmacological Basis of Therapeutics, ed. 4, New York, The Macmillan Company, 1970, p. 537.

Pro-Banthine complements and enhances the action of antacids.

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Medical Department, Box 5110, Chicago, Ill. 60680

occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

Dosage and Administration: The recommended daily dosage for adult oral therapy is one 15-mg. tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

Pro-Banthine P.A.—Each tablet of Pro-Banthine P.A. (propantheline bromide) contains 30 mg. of the drug in the form of sustained-release or timed-release beads; on ingestion about half of the drug is released within an hour and the remainder continuously as earlier increments are metabolized. Thus the result is even, high-level anticholinergic activity maintained all day and all night in most patients with only two tablets daily. Some patients may require one tablet every eight hours.

The contraindications and precautions applicable to Pro-Banthine 15 mg. should be observed.

How Supplied: Pro-Banthine is supplied as tablets of 15 and 7.5 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

Indications: Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. Also, mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: **Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles and Single Unit Packages of 100 capsules.

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Carolina, P.R. 00630
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*Serum Potassium Level Drops During Long-Term Exercise, *Medical Tribune*, July 4, 1973.

†No implication that 'Dyazide' is useful in preventing K^+ loss in athletes is intended.

THE MARATHON WINNER LOSES SERUM POTASSIUM

as a result of intensive physical training.*

MANY HYPERTENSIVE PATIENTS LOSE POTASSIUM†

from therapy with potassium-wasting diuretics.

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Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

SPARES THE HYPERTENSIVE PATIENT'S POTASSIUM AS IT LOWERS BLOOD PRESSURE.

Socio-Economic

MSMS Offers Revisions for Relative Value Study

The MSMS Bureau of Economic Information has prepared a list of revisions to update the 1973 Michigan Relative Value Study for 1974. Following is the first section of RVS revisions for 1974. A second section will be published later.

The revisions include additions and changes since publication of the 1973 edition. The Bureau of Economic Information has provided this listing of revisions so physicians may add them to their copies of the RVS.

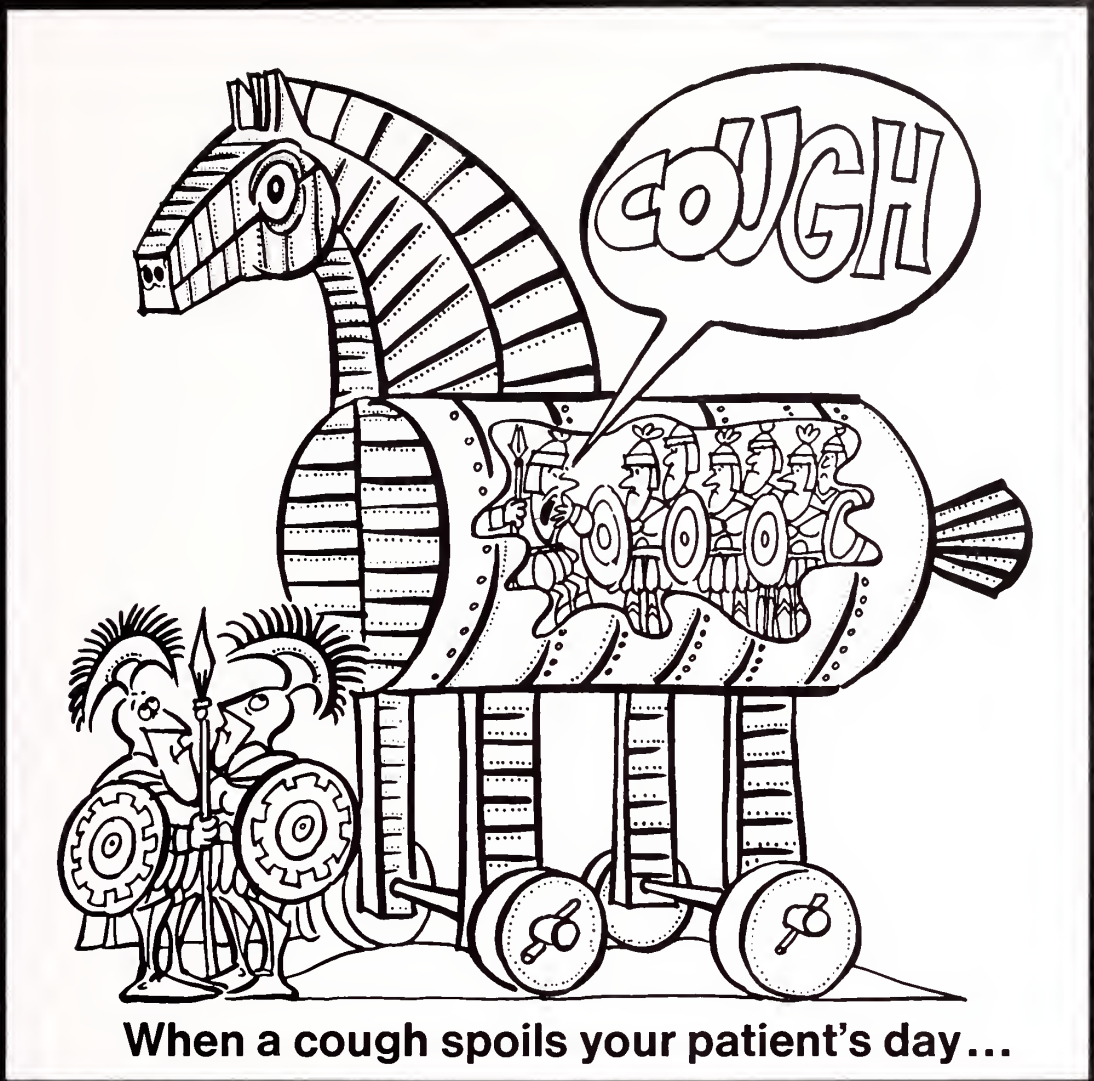
The following are revisions to the Michigan Relative Value Study - 1973. Please revise your study accordingly.

MEDICINE

CPT	OLD MBS	NABSP	DESCRIPTION	RV
90260		9074	Intermediate examination, evaluation and treatment	5
90250		9075C	Limited examination, evaluation and treatment (usual follow-up visit)	3
90285		9080C	Initial examination of newborn in hospital (including discussions with mother during the hospital stay)	7
			Convalescent Care Services	
90320		9090B	Initial visit with history and physician examination, single or multiple patients seen	10
90350		9093F	Routine visit - single patient seen	3
		9094D	Routine visit - more than one patient seen, includes a review of records, examination of patient, and evaluation of treatment programs with progress notes	
		9095A	Brief visit - multiple (more than one patient seen) visit of short duration with patient involving minimal, but identifiable services	
			Rehabilitative Care	
		9130F	Initial hospital care, limited history and physical examination, including initiation of diagnostic and treatment program and preparation of hospital records	8

(Continued)

CPT	OLD MBS	NABSP	DESCRIPTION	RV	ANES.
90320		9131D	Initial hospital care, comprehensive history and physical examination, including initiation of diagnostic and treatment program and preparation of hospital records		10
90350		9135E	subsequent days		3
		9179C	Family counseling, half session		3.5
90840		9184C	Psychologic testing		I.C.
90940		9260A	Hemodialysis, extra corporeal		I.C.
90947		9261I	after four within first 6 months		I.C.
90947		9263E	all subsequent dialysis, after 6 months		I.C.
90960		9267F	Peritoneal dialysis, first four	I.C.	
90960		9268D	after four to first 6 months	I.C.	
90960		9269B	all subsequent, after 6 months	I.C.	
			SURGERY		
			Delete 0180, 0181, 0185, 0186, 0187, 0188		
12000		0182F	Trunk, arms, legs		4.2+
12000		0183D	Scalp, neck, hands, feet, genitalia		4.2+
12000		0184B	Face, ears, eyelids, nose, lips, mucous membrane		4.2+
16000	0340	0400B	Initial treatment, where no more than local treatment necessary	3	4.2+
			BURN DRESSINGS		
		0401J	Initial, without anesthesia, small, office or hospital	4	
		0402H	medium (whole face or whole extremity)	6	
		0403F	large	8	
		0404D	Initial or subsequent under anesthesia, small	8	5.6+
		0405A	under anesthesia, large, 1 hour	20	5.6+
		0406I	under anesthesia, large, 2 hours	40	5.6+
		0407G	under anesthesia, large, 3 hours	60	5.6+
		0408E	under anesthesia, large, 4 hours	80	5.6+
28124	0675	0675I	Phalanx (toes)	18	4.2+
28300	0537	0860G	Os Calcis (Dwyer or Chambers type procedure)	45	4.2+
28302	0537	0861E	Astragalus	45	4.2+
46600	3413	3510E	Anoscopy, diagnostic, with biopsy	2	5.6+
43705	3123	3221I	Gastroscopy, diagnostic, with biopsy	24	5.6+
	3126	3222G	subsequent		5.6+
46760		3532I	Sphincteroplasty, anal, muscle transplant	I.C.	5.6+
68300	5781	5730G	Suture of conjunctiva (ind. proc.)	I.C.	5.6+



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Each teaspoonful (5 ml.) contains:

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PEOPLE

Donald G. Albert, MD, of Royal Oak,

has been elected president of the Michigan Heart Association. Robert M. Daughtery, MD, of East Lansing, was chosen president-elect. Doctor Albert is a cardiologist. Doctor Daughtery is on the faculty of the Michigan State University College of Human medicine.

Leonard F. Bender, MD, of Ann Arbor,

president of the American Academy of Physical Medicine and Rehabilitation, will give a major address at the academy's 36th annual assembly to be held Nov. 17-19 in San Francisco.

Sanford N. Cohen, MD, of New York City,

has been named chairman of the department of pediatrics at the Wayne State University School of Medicine, effective July 1. He also has been named pediatrician-in-chief at Children's Hospital of Michigan. The two positions have been held by Paul V. Woolley, Jr., MD, of Detroit, who is stepping down from the WSU chairmanship and the Children's post, while continuing as professor of pedicatrics and a member of the hospital's staff. Doctor Cohen, a medical graduate of Johns Hopkins University, has been associate professor of pharmacology and pediatrics at the New York University College of Medicine and associate director of pediatrics at Bellevue Hospital, New York City.

Bruce L. Danto, MD, of Detroit,

was among seven alumni of Wayne State University paid special tribute by the WSU Alumni Association at its recent 1974 reunion. Doctor Danto, who did his undergraduate work at Wayne, received his MD degree from the school in 1961. He is director of the Suicide Prevention and Drug Information Center, Detroit Psychiatric Institute, and a member of the WSU psychiatry faculty. Doctor Danto is a frequent contributor to Michigan Medicine and was a delegate to the MSMS House of Delegates at its 1974 annual session.

John M. Dorsey, MD, of Detroit,

is the author of a new book, *Psychology of Ethics*, published by the Center for Health Education, Detroit. The publisher calls the book "an autobiographical accounting," by Doctor Dorsey, "of his systematic development and control of his mental power." Doctor Dorsey, a psychiatrist, has published nine other books.

Nancy E. Furstenberg, MD, of Flint,

has been elected president of the Michigan Thoracic Society. Doctor Furstenberg is director of medical education at McLaren Hospital in Flint. Also elected by the society, the medical advisory group for the Michigan Lung Association, were John G. Weg, MD, of Ann Arbor, vice president, and Rodney R. Bentz, MD, also of Ann Arbor, secretary.

Shivaji R. Gunale, MD, and Leo Zelkowitz, MD, of Kalamazoo,

are the authors of an article on "Polycythemia Vera in Nonagenarian" in the May 27 issue of *JAMA*. The article reports on a case from the Midwest Oncology Center at Borgess Hospital, Kalamazoo.

George E. LaCroix, MD, has left Detroit

to become chief of the Department of Obstetrics and Gynecology at Valley Medical Center in Fresno, Calif. Doctor LaCroix, formerly associated with Hutzel Hospital in Detroit, has been an active member of the MSMS Committee on Maternal and Perinatal Health.

A. Martin Lerner, MD, of Detroit,

was honored recently by the senior class of the Wayne State University School of Medicine. Doctor Lerner, a professor of internal medicine, was presented with the staff award given annually "to the clinical instructor whose conduct, precepts and warmth have in great measure revealed to us the art, science and life of medicine."

Robert E. Mack, MD, of Detroit,

is the author of an article on "Affiliation Agreements Between the University and the Community Hospital" appearing in the May 6 issue of *JAMA*.

Thomas A. Miller, MD, of Ann Arbor,

received the Frederick A. Coller Prize of the Michigan Chapter of the American College of Surgeons at a recent meeting of the chapter in

Detroit. Doctor Miller's winning paper, on "Infected Vascular Prosthesis," was on factors in infection involving vascular grafts. Doctor Miller is a member of the Ann Arbor Veterans Administration Hospital staff and a resident in surgery at the U-M Medical Center. The award honors Frederick A. Coller, MD, former U-M surgery chairman.

John P. Papp, MD, of Grand Rapids, and Frances E. Bull, MD, of Ann Arbor,

are the authors, along with David W. Watson, MD, of Davis, Calif., of an article on "Azathioprine Treatment in Chrohn's Disease" appearing in the February issue of the *American Journal of Gastroenterology.*

F. R. Rhoades, MD, of Detroit,

presented a paper on "Continuous Cyclic Hormonal Therapy" at a recent meeting of the Texas State Medical Society in Houston. Another paper by Doctor Rhoades, with the same title, was published in the April issue of the *American Geriatrics Society Journal,* after earlier presentation to the Southern Medical Association at a meeting late last year in San Antonio.

Joseph A. Rinaldo, Jr., MD, of Southfield,

has been elected president of the American Society for Gastrointestinal Endoscopy. Bernard Schuman, MD, of Detroit, was elected secretary. The election took place at the society's recent annual meeting in San Francisco.

Donald C. Smith, MD, of Lansing,

has been appointed acting director of the Michigan Department of Mental Health by Gov. William G. Milliken. The governor said that Doctor Smith would head a four-member team to review and evaluate departmental policies and programs. Physician members of the team named by Milliken are Raymond W. Waggoner, Sr., MD, and Jacques S. Gottlieb, MD, both former chairmen of the Wayne State University Department of Psychiatry. Doctor Smith continues as head of the State Health Planning Advisory Council and as the governor's health and medical advisor.

Rodman E. Taber, MD, of Grosse Pointe Woods,

has been elected president of the Detroit Surgical Society. He is a member of the attending staff at Harper Hospital and adjunct associate professor of surgery at the Wayne State University School of Medicine. Other officers elected by the society are Arthur J. Johnson, MD, of Detroit, president-elect; Ruth B. Campbell, MD, of Detroit, secretary, and Thomas M. Flake, MD, of Detroit, treasurer.

Mrs. Margaret J. Thoms, of Birmingham,

has been appointed by Gov. Milliken to the Michigan Medical Practice Board as the board's first public representative. Expansion of the board's membership to include a tenth, public member was written into the new Medical Practice Act. Mrs. Thoms is active in community projects and in the Oakland County Republican Party. A graduate of Albion College, with a BA in education, she taught school in Flint from 1945 until 1950. She is the wife of John L. Thoms, an engineer for the Ford Motor Co. and the mother of two sons. Mrs. Thoms's term on the Medical Practice Board runs through Sept. 30, 1978.

Harry A. Towsley, MD, of Ann Arbor,

was honored by the University of Michigan Medical Center recently for leadership in the center's fund drive. The award was given at the dedication of the center's new Furstenberg Study Center, which is named in honor of Albert C. Furstenberg, MD, former dean of the U-M Medical School. Doctor Towsley, professor emeritus of pediatrics and postgraduate medicine, led the fund drive that raised $940,000 from 600 donors to cover most of the cost of the $1,080,000 facility.

John G. Wiegenstein, MD, of East Lansing,

recently was named by the AMA board of trustees to a one-year term on the AMA Committee on Community Emergency Services. Doctor Wiegenstein is a member of the board of directors of the American College of Emergency Physicians.

Medical Student's View

H/D Participation Produces New Insights

By Bryan P. Shumaker, Southfield

On a cold, damp Sunday afternoon in May, the 109th Annual Session of the MSMS House of Delegates began at Boyne Mountain. Some of the delegates had high hopes of things to be accomplished; others, more cynical in nature, viewed the proceedings with less optimism. For a medical student, however, this was an opportunity both to participate in and to view first-hand the intricate goings-on of an organization which is traditionally lumped by students with "establishment" and "organized medicine."

I was one of six medical students at the meeting and, for us, the first order of business was an informal caucus to decide which committee meetings we should attend. We agreed to split up to cover several different reference committees. I already had decided to attend the Constitution and Bylaws Committee because I wanted to discuss a proposal for a "student member" category in the society.

Bryan Shumaker

Many Ideas

The real politicking, as I already knew, takes place in informal gatherings, not at meetings. In the bar, with a name tag on my lapel and a Tom Collins grasped firmly in my hand, I proceeded to meet and talk with physicians from all over the state, to discuss their ideas and opinions on everything from PSROs to housestaff organizations. Not only was this enjoyable in that I met many new people and saw old friends, it was also quite enlightening. Most physicians felt similarly about many things, usually regardless of where they practiced.

With other students I attempted to talk with Rep. Guy Vander Jagt, one of the speakers at Sunday night's MDPAC dinner, about national health insurance legislation. We were startled by his self-admitted lack of knowledge about the details and consequences of the major health bills being considered by Congress.

The MDPAC program, however, was excellent, presided over by Louis R. Zako, MD, who always impresses me with his seemingly unlimited energy and organizational capabilities.

Out-State Caucus

The next big event of the evening was the Out-State Caucus, where I learned that point of view depended somewhat on the home town of the person expressing himself. This provided an historical perspective of past political machinations and policy-making in MSMS and gave me a greater insight into the feelings which generated some of the resolutions.

(Continued on Page 408)

Bryan Shumaker is a fourth year student at Michigan State University's College of Human Medicine who is continuing his studies off-campus this summer at Hurley Hospital in Flint. He did his undergraduate work at Wayne State University where he majored in history. He is a student advisor to the MSMS Committee on Planning and Priorities and is a student representative on the program operating committee of the Cooperative Michigan Primary Care Preceptorship Program. He served in 1972 as MSU coordinator for the Student American Medical Association Project for Medical Education and Community Orientation, coordinated by MSMS. The views expressed in this article are his own and do not represent opinions of MSMS or the staff of Michigan Medicine.

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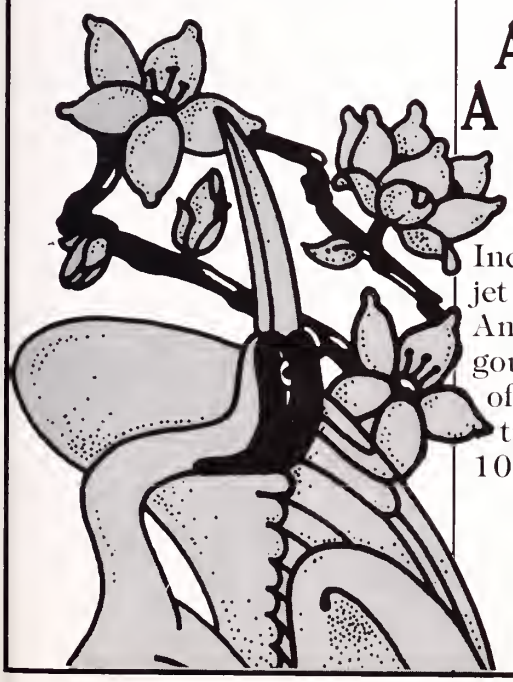
Join us for two weeks on a carefree, do-as-you-please holiday in Tokyo and Hong Kong. Everyone should

have at least one adventure a year, and this could be yours . . . spectacular harbors, towering volcanic peaks, the glitter and frenzy of the Ginza, lush Nikko National Park, the intricacy of Buddhist temples, graceful geishas, exotic cuisine, and tempting buys in jade, pearls, silk, cameras and antique rosewood furniture. It all awaits you.



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I attended the Constitution and Bylaws Committee to protest the addition of the student MSMS membership category. As proposed, the student "member" would not pay dues, but could not vote, hold office or be eligible for member benefits. He could receive "publications authorized by the Council" and speak before or be a member of various MSMS committees. This was irritating in that several of us already are serving on MSMS committees and play a role in their functions, although we are not members.

'Impotent'

We felt that this wording rendered the student so impotent as a member as to not make it worth his while to even apply for membership. Although the students felt that the vote was unimportant at present (students already are represented by three voting delegates, one from each school) and students probably should not hold office because of their inexperience, we felt that at least some benefits could be extended to students. These might include insurance, reduced car rental rates or vacation packages. In addition, the wording of this section was so negative that it was destructive. A student considering MSMS membership might stalk off in disgust after reading this section.

Delegates Listen

To my pleasant surprise, the members and delegates attending the Constitution and Bylaws Committee meeting were very friendly and receptive toward my views and feelings, which were admittedly a gut reaction. There was a genuine desire to involve the student more and I was asked how this could best be done. It quickly became apparent that the involvement must start at the county level and we discussed various ways students might be encouraged to take on increasing responsibility and involvement during their school years so that: (1) after graduation they might be more inclined to practice in Michigan in that they already would be intimately involved in Michigan medicine, and (2) that these active students would have a four-year "head start" in organized medicine and could become dynamic and mature leaders at an earlier time in their careers.

Can Be Amended

After some discussion, it was decided to propose incorporating the wording as it stood, in that it would be easier to amend it at a later date than go through the process of first and second readings at this time. It was nonetheless a good learning experience, particularly concerning the technical process for moving a resolution along to become accepted, formal policy.

I have two other major observations to make.

The first concerns the large number of resolutions concerning PSROs. It is too repetitive to delve into the controversy and future implications surrounding this bill. What annoyed me was the presence of resolutions which in one way or another "played ostrich" with the problem by condemning PSRO and hoping it would go away on its own. Thankfully, there are far-sighted individuals who realize that PSRO already is law with little chance for repeal and that it would be best for the physician to cooperate with PSRO and obtain control of it. This is particularly important to the new physician and student who will spend their entire professional careers under policies and controls which are made now.

Time Could Be Saved

My second observation deals with the large amount of wasted time at the formal House of Delegates session over matters which could conceivably be handled more expeditiously. This "dynamic inactivism" gives the impression of much accomplishment when in actuality the reverse is true. Although the right to speak is an integral part of any democratic organization, it can also be self destructive when it interferes with more important business at hand.

In retrospect, this three-day experience allowed me to become cognizant of physicians' feelings and views on a variety of medical issues, enabled me to voice my own attitudes and ideas and, most importantly, let me come away with a truer concept of organized medicine as a group basically dedicated to its present and future members.

Must vasodilators and therapy for other diseases come into conflict?

not if the vasodilator is

VASODILAN®
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the compatible vasodilator... no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows.

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

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Medico - Legal

Judicial Commission Advises Physicians to Comply Fully with Death Certificate Law

The MSMS Judicial Commission has issued a strong reminder to physicians that Michigan law requires that death certificates be completed and signed by attending physicians within 24 hours of death.

John W. Grigg, MD, of Bay City, Judicial Commission chairman, reported that MSMS had been informed of some problems arising over physicians' failure to complete the required documents within 24 hours of the deaths of patients.

Doctor Grigg said that problems are most likely to arise in cases of hospitalized patients who are under the care of attending physicians who make hospital rounds only once daily. While the patient may be pronounced dead by an intern or resident, the attending physician is responsible for signing the death certificate.

At its May 22 meeting, the Judicial Commission concurred that ethics demand that physicians abide by the law, including the 24 hour provision. The commission further agreed to inform the Michigan Funeral Directors Association that should a mortician have a complaint against a specific physician, the complaint should be reported to the ethics committee of the physician's county medical society. If this process should prove unsatisfactory, a written complaint can be made directly to the Judicial Commission, Doctor Grigg said.

For the information of physicians, the statute covering responsibility for death certificates follows:

Certificate of death; contents; disposition permit.

"The funeral director or person having charge of a corpse shall file the certificate of death or stillbirth with the registrar of the district in which the death or stillbirth occurred and obtain a burial or removal permit prior to disposing of the body, subject to the provisions of section 6. He shall obtain the required personal and statistical particulars over the name and address of his informant. The attending physician or in the absence of an attending physician, the coroner shall fill out and sign the medical certificate of death or stillbirth within 24 hours after death. The funeral director shall then state over his signature and address the date and place of intended burial, cremation or to which the body is to be removed, and present the completed certificate to the registrar for a permit for burial, removal or other disposition of the body.

"The name of each person who signs the certificate of death or stillbirth shall be legibly printed, typewritten or stamped upon the certificate immediately beneath the signature of the person. The permit shall be delivered to the person in charge of the place of burial before the body is interred or otherwise disposed of. If the body is to be shipped, the permit shall be attached to the box containing the same and shall be delivered to the person in charge of the place of burial if within the state."

bear. Thus, a poor economic area got only what medical service it could pay for and that was often inferior medical service. Such an area could support only a few physicians, all of whom were overworked, rushed and forced to see a large volume of patients rapidly for low individual payments.

Everyone sees the problem with this. Of necessity it had to change, and of necessity the state and federal governments gradually tried to improve such situations. Gradually Medicare and Medicaid came into being. This was necessary to provide uniform medical services to citizens throughout the country and I believe it is good. But, with Medicare and Medicaid came controls and unfortunately with controls came the edict that medical services would only be reimbursed at the same levels that they always used to be, depending on location. This was bad! This created the current problem by perpetuating an old problem in paying more in well to do areas and attracting more physicians there and paying less in poor areas and discouraging adequate numbers of physicians and medical services in these areas.

Payment for services is now locked in by law, not by local economic conditions and unfortunately payments are locked in at levels established under poor economic conditions. Thus the government has locked into law an archaic rule essentially saying that medically deprived areas shall continue to receive less medical care and medically rich areas shall continue to constantly be built into richer and richer medical areas. This stringent barrier to the adequate development of medical services to rural areas must be reversed. Residents throughout the state all uniformly pay the same state and federal taxes. Those unfortunately located in the rural areas are discriminated against in that governmental third party payers return less of their money to their locale and send more of it to the metropolitan areas.

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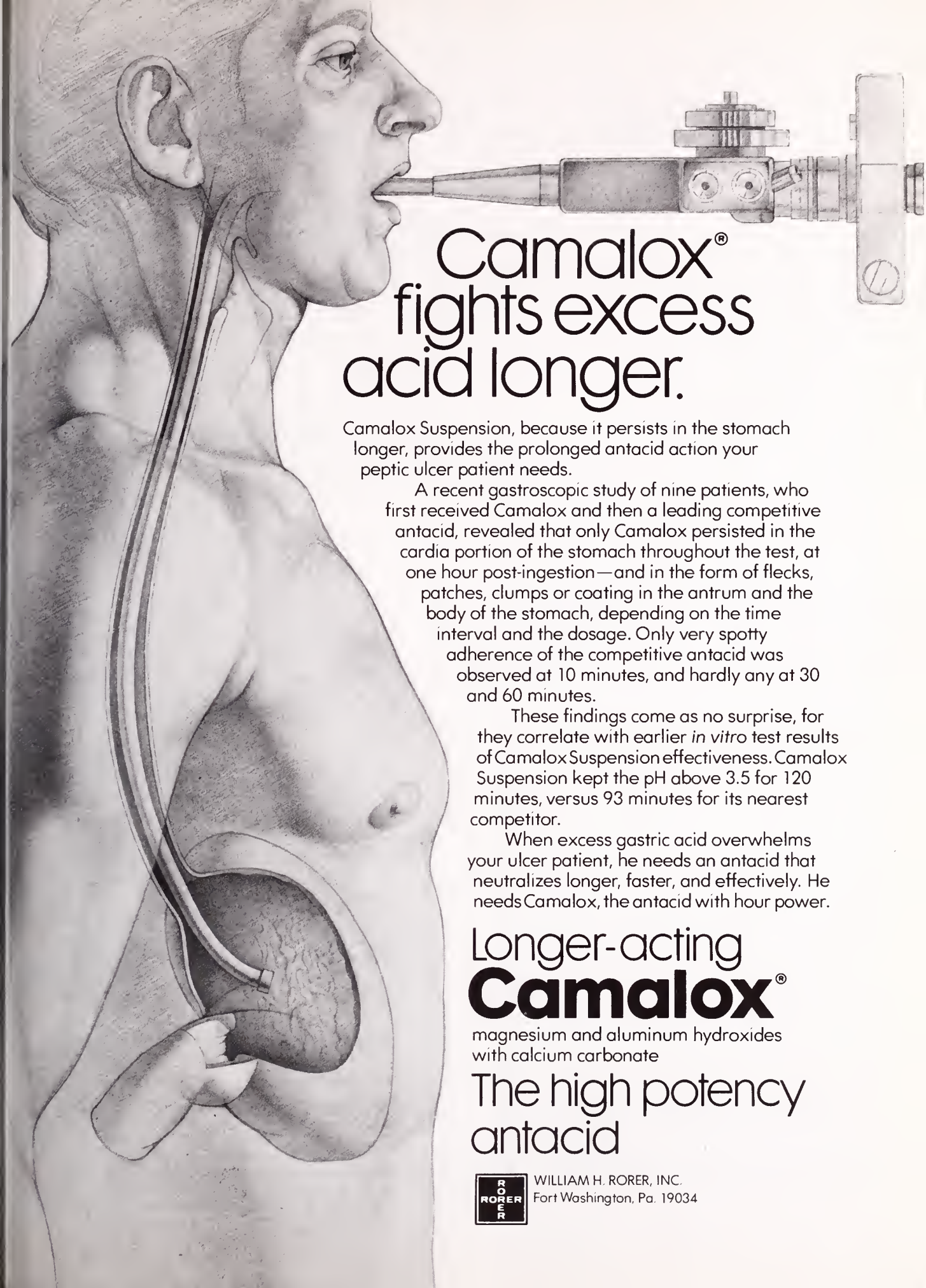

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MEETINGS

July 6-10—Michigan Academy of Family Physicians Annual Meeting and Scientific Program, Park Place Motor Inn, Traverse City, contact: MAFP office, 933 Wing St., Plymouth, Mich. 48170.

July 12-13—North Central Regional Meeting on "Primary Care in Group Practice" sponsored by the American Association of Medical Clinics at the Merrillville (Ind.) Holiday Inn, contact: L. W. Neal, MD, Hammond Clinic, Munster, Ind. 46321.

July 25-27—Annual Coller-Penberthy-Thirlby Medical Conference, Park Place Motor Inn, Traverse City, contact: Laurence P. Skendzel, MD, Munson Medical Center, Traverse City, Mich. 49684.

July 25-28—Summer meeting of the Michigan Psychiatric Society, Inn on the Park Hotel, Toronto, contact: Charles W. Davenport, MD, University Hospital, Ann Arbor, Mich. 48104.

July 27-28—Summer seminar sponsored by the American Association of Medical Assistants — State of Michigan, at Schuss Mountain, Mancelona, contact: Mrs. Claire Van Dam, 1591 S. Riviera, Stevensville, Mich. 49127.

July 31—Intensive one-day postgraduate course for physicians on alcoholism, sponsored by the Central States Addictions Institute in cooperation with the American Medical Association, at the American Hospital Association Headquarters, Chicago, contact: James W. West, MD, Central States Addictions Institute, 122 S. Desplaines St., Chicago, Ill. 60606.

Aug. 1-3—MSMS Council, St. Clair Inn, St. Clair, contact: Warren F. Tryloff.

Aug. 5-7—27th Annual Conference on Aging, on the theme "State-wide Systems of Higher Education and Gerontology," sponsored by the Institute of Gerontology, at Ann Arbor, contact: Wayne Vasey or Charles Parrish, Institute of Gerontology, 543 Church St., Ann Arbor, Mich. 48104.

Sept. 9-11—Continuing education course on "Early Care of the Injured Athlete" produced by the Committee on Sports Medicine, American Academy of Orthopaedic Surgeons in cooperation with the University of Michigan at U-M, Ann Arbor, contact: American Academy of Orthopaedic Surgeons, 430 N. Michigan Ave., Chicago, Ill. 60611.

Sept. 23-27—Family practice review, sponsored by the Michigan Academy of Family Physicians, at Scott Hall, Wayne State University School of Medicine, contact: MAFP office, 933 Wing St., Plymouth, Mich. 48170.

Sept. 25—MSMS Council, MSMS Headquarters, contact: Warren F. Tryloff.

Sept. 27-29—Michigan Regional Meeting of the American College of Physicians, Otsego Ski Club, Gaylord, contact: Beverly C. Payne, MD, 425 E. Washington St., Ann Arbor, Mich. 48108.

Oct. 1—Annual surgical symposium, "Surgical Disease of the Pediatric Gastrointestinal Tract," sponsored by the Department of Surgery, Children's Hospital of Michigan, and Wayne State University School of Medicine Department of Surgery, at the hospital, contact: Department of Community Relations, Children's Hospital of Michigan, 3901 Beaubien Blvd., Detroit, Mich. 48201.

Oct. 4—Mid-year Meeting, Michigan Hospital Association, Park Place Motor Inn, Traverse City, contact: MHA office, 2213 E. Grand River Ave., Lansing, Mich. 48912.

Oct. 9-10—1974 Annual MSMS Scientific Meeting, Sheraton-Cadillac Hotel, Detroit, contact: Helen Schulte, MSMS Headquarters.

Oct. 9—Annual MSMS Leadership Conference and MSMS Awards Luncheon, Sheraton-Cadillac Hotel, Detroit, (in conjunction with the Annual Scientific Meeting), contact: Herbert A. Auer, MSMS Headquarters.

Oct. 11-12—Annual reunion of the University of Michigan Medical Center Alumni Society, Ann Arbor, contact: Robert Richards, Towsley Center, Ann Arbor, Mich. 48104.

Oct.31-Nov. 2—Course on "Implant Surgery for Joints and Tendons in the Hand," sponsored by the American Society for Surgery of the Hand, at Blodgett Memorial Hospital, Grand Rapids, contact: Alfred B. Swanson, MD, 313 Blodgett Medical Bldg., Grand Rapids, Mich. 49506.

Nov. 6—MSMS Council, MSMS Headquarters, contact: Warren F. Tryloff.

Dec. 11—MSMS Council, MSMS Headquarters, contact: Warren F. Tryloff.

Michigan Medicine each month lists upcoming meetings in Michigan or of special interest to Michigan physicians if out of state. Please submit notices for publication at least two months prior to meeting dates.

Welcome

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

Herbert A. Atkinson, MD, 1250 Dean's Hill Rd., Berrien Center 49102
Solomon Bazini, MD, Parklane Towers, Dearborn 48126
William J. Behrje, MD, 1631 Gull Rd., Kalamazoo 49001
Savitri Bhama, MD, Veterans Administration Hospital, Allen Park 48101
Harold E. Brown, MD, 802 Front St., Buchanan 49107
Kathleen E. Carpenter, MD, 612 S. Bay Shore, Elk Rapids 49629
Nereide Casu, MD, 10281 Gratiot, Detroit 48213
Young Ha Chi, MD, 810 W. Saginaw, Lansing 48910
John E. Desguin, MD, 1850 Abbott Rd., East Lansing 48823
Harshad Kum ar Doshi, MD, 777 D Riverview Dr., Benton Harbor 49022
Maria Z. Fernandez, MD, Hutzel Hospital, Detroit 48201
Anthony C. Halat, MD, 14913 Archdale, Detroit 48227
Marigeppa N. Hattarki, MD, 1838 Kreiser St., SE, Grand Rapids 49506
Clinton L. Holt, MD, Upjohn Co., Kalamazoo 49001
Ali Kafi, MD, 3800 Woodward, Detroit 48226
Antonius M.T.G. Kam, MD, 2548 Creek Bluff Pl., NW, Grand Rapids 49504
Nelson S. Keeler, Jr., MD, 25801 McAllister Rd., Southfield 48075
Dong Soo Kim, Hillcrest Center, Howell 48843
Richard C. Klugo, MD, Henry Ford Hosp., Detroit 48202
David W. Knox, MD, 3800 Applewood, Midland 48640
Dennis G. Laug, MD, 211 High St., Northport 49670
Tjin Lie Lim, MD, 8020 Davison Rd., Davison 48423
George B. Lorenzo, MD, 12200 E. Jefferson, Detroit 48226
Charles P. Lucas, MD, 432 E. Hancock, Detroit 48201
James E. Lynch, MD, 521 Mulford Dr., SE, Grand Rapids 49507
Alma Irene MacLeod, MD, 29226 Orchard Lake Rd., Farmington 48024
Fred Matthies, MD, 1210 W. Saginaw, Lansing 48914
Robert W. Mendelson, MD, 11885 E. 12 Mile Rd., Warren 48093
Erlinda P. Mercado, MD, 1615 W. Big Beaver Rd., Troy 48084
Khalid Mian, MD, 1634 Gull Road, Kalamazoo 49001
Derek H. Miller, MD, 2900 Heatherway, Ann Arbor 48104
B. H. Nanavati, MD, 207 Scallon Ave., Hancock 49930
Robert L. Newhouse, MD, 403 State, Traverse City 49684
Helene M. Olson, MD, 1250 Dean's Hill Rd., Berrien Center 49102
Moon Ki Paik, MD, 28477 Hoover Rd., Warren 48093
Moon J. Pak, MD, Ph.D., Oakland Univ., Rochester 48063
John E. Pasko, Jr., MD, 750 Stewart Rd., Monroe 48161
Mohamed-Grous A. Patel, MD, 8300 Mack Ave., Detroit 48214
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Muhammad Rafi, MD, Upjohn Co., Kalamazoo 49001
Dale H. Rice, MD, 3277 Bolgos Circle, Ann Arbor 48108
Howard B. Schwartz, MD, 24157 Van Dyke, Centerline 48105
David R. Scott, MD, Three Fountains Apts., Midland 48640
Donald N. Shapiro, DDS, 26711 Woodward Ave., Huntington Woods 48070

(Continued)

Barry L. Siegel, MD, 555 E. William St., Ann Arbor 48108
Amelia L. Sikora, MD, 3677 Fort St., Lincoln Park 48146
Hanna T. Sisley, MD, 32905 W. 12 Mile Rd. #320, Farmington 48024
Michael W. Smith, MD, Chelsea Medical Clinic, Chelsea 48118
Alfred H. Sokolowski, MD, 27970 Orchard Lake Rd., Farmington 48024
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Veera Sripinyo, MD, 6700 Lynch Rd., Detroit 48235
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John J. Stiles, MD, 137 Glenview Dr., Paw Paw 49079
Ron C. Terrill, MD, 347 Bostwick, NE, Grand Rapids 49503
Larry G. Thompson, MD, 524 Fifth St., Traverse City 49684
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Ramesh K. Vaidya, MD, 48681 Denton Rd., Belleville 48111
Ronald L. VanderMolen, 880 Woodward Ave., Pontiac 48053
Richard J. VanKolken, MD, 1288 Lakeshore Dr., Grand Haven 49417
Ganesh K. Vatthyam, MD, Henry Ford Hospital, Detroit 48202
Thomas R. Winh, MD, St. Francis Hospital Escanaba 49829.
Leslie B. Wong, MD, 1808 Rossman, SE, Grand Rapids 49506
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References: 1. Reuter, S. H., and Montgomery, W. W.: Arch. Otolaryng. *80*:214-217 (Aug.) 1964. **2.** Osol, A., et al., ed.: The United States Dispensatory and Physicians' Pharmacology, ed. 26, Philadelphia, J. B. Lippincott Co., 1967, p. 171. **3.** Schwartz, A. D., and Pearson, H. A.: J. Pediat. *78*:558-560 (March) 1971.

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In Memoriam

Thomas A. Boutrous, MD
Bloomfield Township

Thomas A. Boutrous, MD, 62, of Bloomfield Township, a Detroit area surgeon since 1944, died May 20 in Mt. Carmel Mercy Hospital, where he formerly served as chief of staff and chief of surgery.

A graduate of the Northwestern University Medical School, Doctor Boutrous was a member of the first board of directors of St. Jude's Research Hospital in Memphis. He was a diplomate of the American College of Surgeons and a member of the International College of Surgeons.

William A. Fellner, MD
Detroit

William A. Fellner, MD, 48, of Detroit, a specialist in industrial medicine, died June 8 in an auto accident. Doctor Fellner, a graduate of the University of Michigan Medical School, served in the navy during World War II. He was medical director of the Chevrolet Gear and Axle Plant, Detroit.

Waldemar B. Hartmann, MD
Mt. Clemens

Waldemar B. Hartmann, 62, of Mt. Clemens, who practiced general medicine and general surgery in the Detroit area for 35 years, died June 7 in St. Joseph Hospital, Mt. Clemens. Doctor Hartmann was a graduate of the Wayne State University School of Medicine and belonged to the American College of Gastroenterology.

Ruth Herrick, MD
Lowell

Ruth Herrick, MD, 78 of Lowell, who retired a year ago after more than 40 years practice of dermatology, was killed June 9 in an automobile accident in Indiana. Doctor Herrick, a graduate of Rush Medical College in Chicago, was one of the first women to practice medicine in Kent County. She practiced in Grand Rapids until moving to Lowell 12 years ago.

Doctor Herrick had been on the staffs of Blodgett Memorial, Butterworth and St. Mary's hospitals in Grand Rapids. Doctor Herrick had built a private museum in Lowell to display her extensive glass collection.

Louis H'Romadko, MD
Birmingham

Louis H'Romadko, MD, 79, of Birmingham, a Detroit area surgeon and proctologist since 1926, died March 21. A graduate of the University of Michigan Medical School, Doctor H'Romadko was a life member of MSMS. He was a fellow of the American College of Surgeons and received a special award from the college in 1940. He had served on the staff of St. John Hospital in Detroit.

Jarvis M. Hyatt, MD
Dearborn

Jarvis M. Hyatt, MD, 60, of Dearborn, a family physician affiliated with Oakwood Hospital, died Jan. 18. A graduate of the Wayne State University School of Medicine, Doctor Hyatt served in the army during World War II.

William J. Kane, MD
Mt. Clemens

William J. Kane, MD, 82, a past president of the Macomb County Medical Society, died May 24 at his home. Doctor Kane was graduated from Wayne State University School of Medicine in 1916 and served with the army in France in 1918 and 1919 before establishing his private practice.

He served for 25 years as Mt. Clemens health officer and was medical director of Martha T. Berry Memorial Hospital from 1956 to 1964. He also served three terms as chief of staff at St. Joseph Hospital. He was a life member of MSMS.

Clinton J. Mumby, MD
Royal Oak

Clinton J. Mumby, MD, 66, of Royal Oak, an Oakland County psychiatrist for 30 years, died May 30 while on a visit to London. A graduate of the Wayne State University School of Medicine, Doctor Mumby served as an army psychiatrist in Europe during World War II. He was on the staff of Pontiac General Hospital and served as a consultant to Oakland County Juvenile Court.

William G. Paine, MD
Lansing

William G. Paine, MD, 60, of Lansing, a specialist in internal medicine, died May 22. Doctor Paine, a graduate of the University of Michigan Medical School, had practiced in Louisiana and Missouri as well as Michigan. He was a retired commander in the naval reserve. Doctor Paine was on the staffs of Sparrow, St. Lawrence and Ingham Medical hospitals.

Edward L. Robb, MD
Gaylord

Edward L. Robb, MD, 79, of Gaylord, a retired Detroit physician, died May 31 in his home. Doctor Robb was graduated from the Wayne State University School of Medicine in 1921 and had practiced in Detroit for 50 years prior to his retirement in 1971. He was a life member of MSMS.

(Continued on Page 420)

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Harold Riche Roehm, MD
Bloomfield Hills

Harold Riche Roehm, MD, 77, of Bloomfield Hills, who provided leadership in development of the residency program in pediatrics at St. Joseph Mercy Hospital in Pontiac, died May 29 in the hospital.

Doctor Roehm was graduated from the University of Michigan Medical School and was a life member of the American College of Physicians, the American Academy of Pediatrics, the Detroit Historical Society and MSMS.

Max Silverman, MD
Detroit

Max Silverman, MD, of Detroit, Dearborn city physician, died June 9 at the age of 80. Doctor Silverman was graduated from Tufts University School of Medicine in Boston in 1916.

Doctor Silverman served on active duty with the navy from 1917 until 1946 when he retired with the rank of captain. He was a life member of MSMS.

Stelios N. Sakorraphos, MD
Belmont, Mass.

Stelios Nicholas Sakorraphos, MD, 87, of Belmont, Mass., a former Detroit area urologist, died Feb. 17. Doctor Sakorraphos received his medical education at the National University of Athens in Greece and did post graduate work in urology at the University of Pennsylvania before coming to Michigan in 1928. He was a life member of MSMS.

Ernest C. Schultz, MD
Detroit

Ernest C. Schultz, MD, 83, a Detroit otolaryngologist for many years, died May 25. Doctor Schultz was a graduate of the Albany Medical College of Union University. He was a life member of MSMS.

John T. Sydnor, MD
Detroit

John T. Sydnor, MD, 63, a Detroit family physician, died May 4. He was a graduate of the Howard University College of Medicine in Washington, D.C. Doctor Sydnor founded the First Independence National Bank of Detroit.

Paul H. Wilcox, MD
Traverse City

Paul H. Wilcox, MD, 67, noted Traverse City psychiatrist and neurologist, died May 23 in Newton, Mass. Doctor Wilcox founded the Electroshock Research Association and published extensively in scientific journals. He was a past president of the American Society of Medical Psychiatry.

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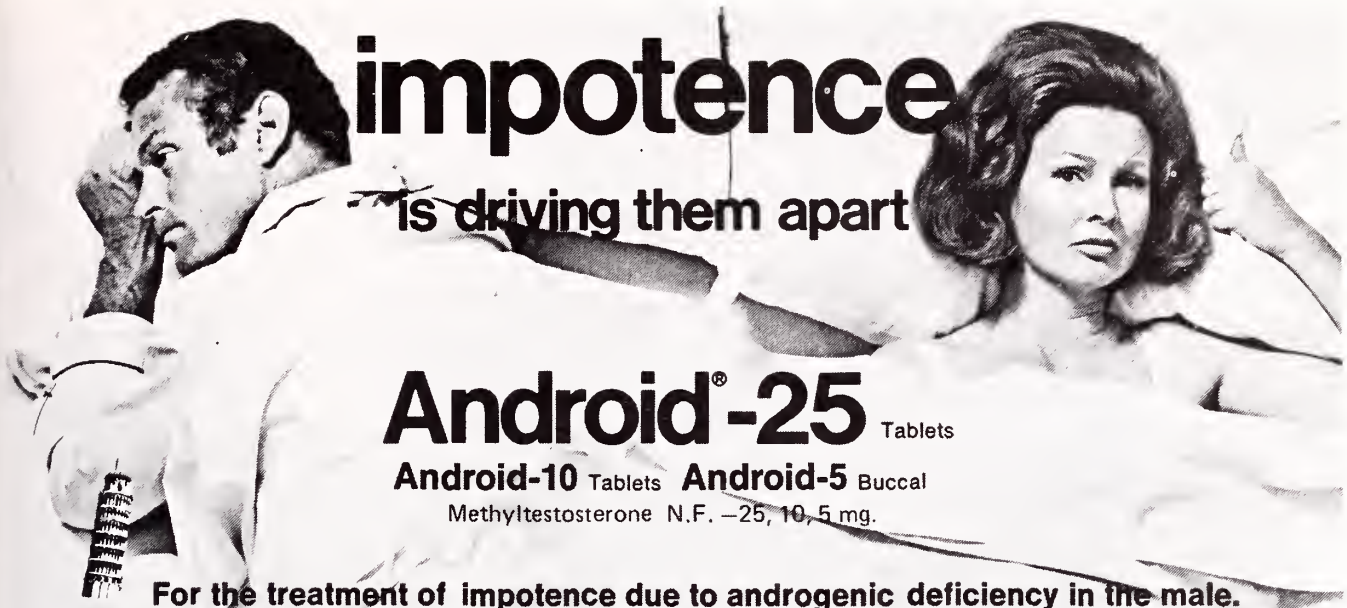
Inquiries should be addressed to Cyril M. Worby, M.D., Chairman, Search Committee, Department of Psychiatry, A-222 East Fee Hall, Michigan State University, East Lansing, Michigan 48824.



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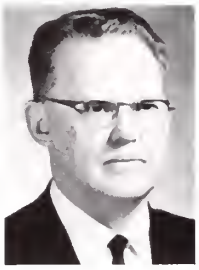
Beating the Deadline

By Herbert A. Auer, Executive Editor

Dr. Schnute



Dr. Dick

Dr. Heilbronn

Dr. Towsley

Dr. Rawlings

The Calder Plaza in Grand Rapids was the setting for a recent community farewell party for a husband and wife pediatrics team, **Louise F. Schnute, MD,** and her husband, **Mark W. Dick, MD,** who have retired from practice and moved to Colorado. Several years ago the doctors hired a Spanish tutor for lessons for themselves and members of their staff to improve communication with patients from the Latin-American community.

Duane B. Heilbronn, MD, of Saginaw, is the new president of the Saginaw County Medical Society, the only component that elects in mid-year. **Barry F. Waite, MD,** of Saginaw, was selected as president-elect. **John E. Finger, MD,** of Saginaw, retired as president.

Another young physician who has returned to his home town to practice is **Michael McAuliffe, MD,** who is back in Adrian after completeing graduate training in internal medicine at St. Joseph Hospital, Ann Arbor. Doctor McAuliffe is a graduate of the University of Notre Dame and the Northwestern University Medical School.

Grant Harrison Laing, MD, 81, noted Chicago medical educator and researcher who was born in Iron Mountain, was honored by the Iron Mountain-Kingsford Rotary Club recently for his distinguished career. He received the Rotarians' 10th annual Native Son Award and was feted during "Grant Harrison Laing Day" proclaimed by the Iron Mountain mayor and council. Doctor Laing was graduated from Rush Medical College in Chicago in 1921.

Jacob Bruggema, MD, of Evart, was honored recently by his community for his many years of medical service. While active in hospital and medical society matters, he also has found time to serve on the Evart city council and the board of education for 26 years.

"And he is a darned fine trout fisherman," added the president of the Michigan Public Health Association as he presented a certificate for community service to **Harry A. Towsley, MD,** of Ann Arbor. Ralph E. Lewis made the award to the U-M professor emeritus of pediatrics and postgraduate medicine.

J. Mott Rawlings, MD, who retires this month as associate director of the C.S. Mott Center of Human Growth and Development at Wayne State University was honored at a recent Detroit dinner. He formerly practiced in Flint.

Best golfers at the annual meeting of the Michigan Chapter of the American Academy of Pediatrics at the Bay Valley Inn were **Richard Bickham, MD,** of Bay City, low gross, and **Daniel Wilhelm, MD,** Port Huron, low net.

This page will appear each month with news items "on the human side" gathered from correspondence, meetings, conversations and tips we hope you will send in from time to time.

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

For further information on this subject, the following references are provided:

1. Henry BW, *et al: Dis Nerv Syst 30*:675-679, Oct 1969.
2. Hollister LE, *et al: Arch Gen Psychiatry 24*:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970.

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2-mg, 5-mg, 10-mg tablets

in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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This month Michigan Medicine joins in the centennial tribute to St Mary's Hospital, Saginaw, with a feature article about the hospital and the publication of two scientific articles by members of the hospital's staff beginning on page 437.

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The cover photograph, of a Lake Michigan scene near Saugatuck, is by Thomas R. Roberts, Lansing.

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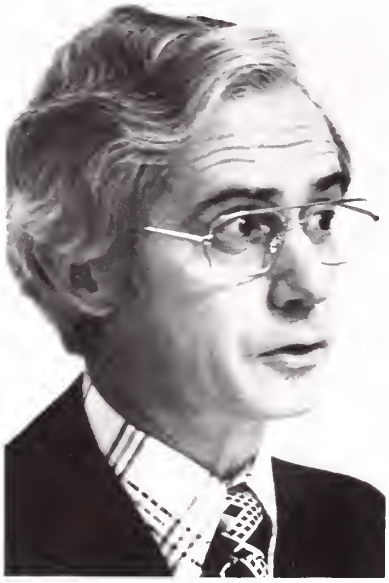
President's Page

POLITICS . . . the Name of the Game



Doctor Masters

Michigan's generic drug substitution law will become effective Jan. 1 of next year, permitting a patient to ask for a lower priced drug than that prescribed by the doctor, or for the pharmacist to suggest and dispense a lower priced medicine.

The measure, House Bill 4145, has become law although hardly anyone, proponents or opponents, considered it a "good bill." Perhaps not a "bad bill," it just won't do what it promises.

— It is another harrassment to good medical practice.

— It will produce only questionable cost savings; most testimony forecast a maximum savings of 5 per cent.

— The pharmacists' cost of doing business will go up. In my area I could not find a pharmacist who favored the bill.

So, why has the bill passed?

MSMS opposed the measure from its introduction in February, 1973, on the grounds that it would not guarantee savings to consumers as alleged and that it could, in fact, result in harm to patients because of serious problems in generic and therapeutic equivalency. (A last-minute amendment jointly sponsored by medical, osteopathic and hospital association leaders added a safeguard to physicians and patients by permitting physicians to specify "dispense as written" or "DAW" on prescription pads.)

It appeared from the time of introduction that the bill would pass, but why?

We obviously have seen a demonstration of the power of labor union leadership, both state and national. I doubt that the rank-and-file union member is much aware of the implications of the bill, but the leaders came out "four square" publicly for the professed advantage of the bill: *cost savings.* Their objective was to "do something" for their membership. One must wonder at such leadership if the cost savings cannot be substantiated and if the harrassment of such an act will really detract from the quality of medical care they are also attempting to bring their members.

The Michigan Pharmaceutical Association also co-sponsored this bill. I assume this will be a good point at which to start the upcoming dialogue between MSMS and the MPA. Various consumer groups also supported the bill.

This new law is the visible result of a popular cry, "Health care is too expensive." Organized medicine needs to keep its antennae at full alert in the months to come, for don't we hear the same siren's song in HMO, NHI, PSRO, CHP, etc., etc?

Perhaps we can see a lesson in the politics surrounding the generic drug bill, gaining useful information for the struggles that lie ahead. We have potent political opportunity in our daily patient contacts, 1,500,000 weekly in Michigan alone. We must take the time to discuss with our patients the pitfalls of bills similar to HB 4145 in the future. The voice of the voter in that amorphous mass, the public, is what makes politics the name of the game.

Brooker L. Masters, MD

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1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

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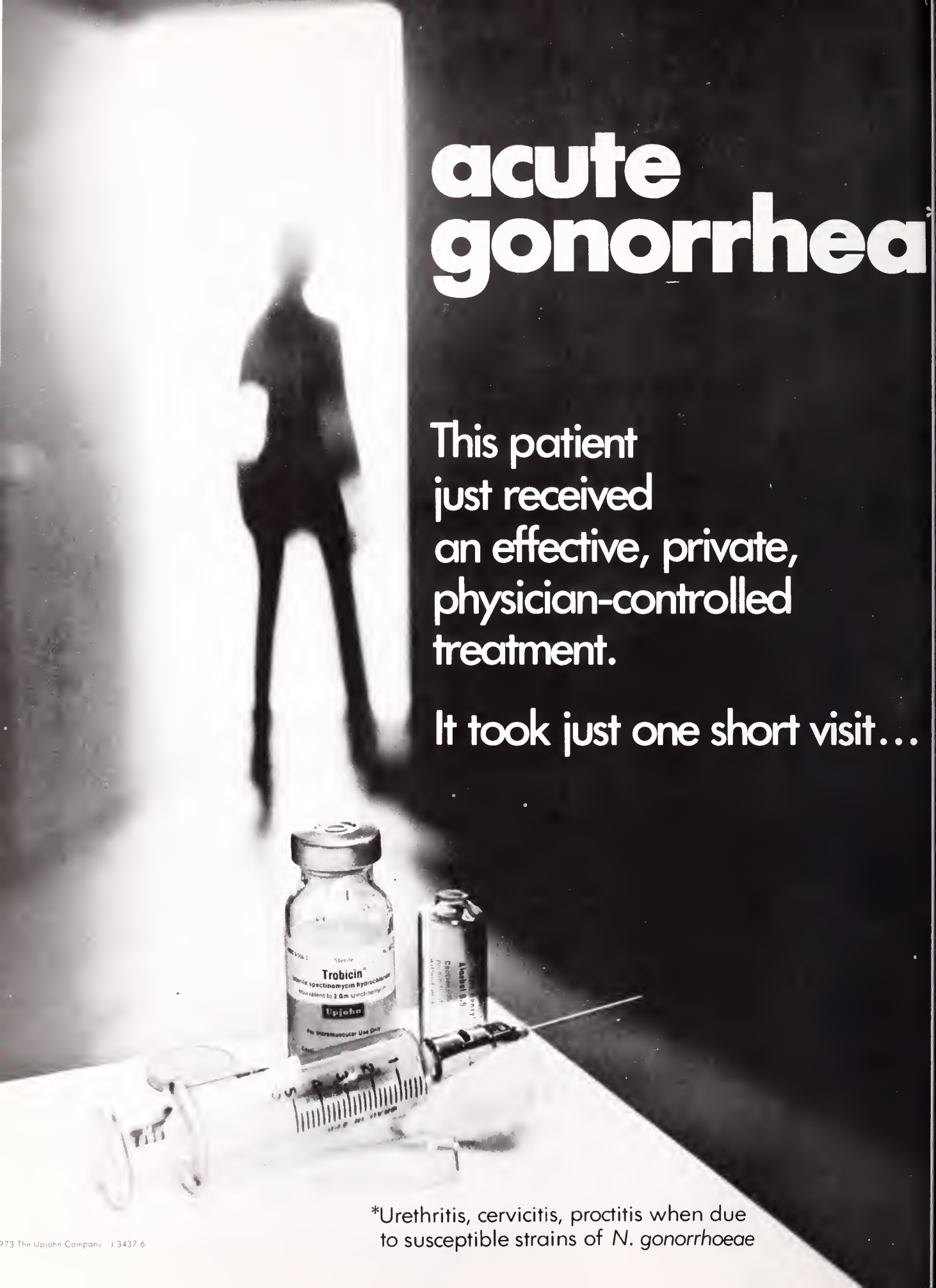

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Trobicin—Indication and dosage.
Spectinomycin is indicated only for use in acute urethritis and proctitis in the male and acute cervicitis and/or proctitis in the female when due to susceptible strains of *N. gonorrhoeae*. The usual dosage for Trobicin in adult males is 2 grams intramuscularly†; 4 grams intramuscularly in females.

Trobicin—Not effective for syphilis.
Trobicin is not effective for any stage of syphilis. Trobicin may mask or delay the symptoms of incubating syphilis. If concurrent syphilis is suspected, follow the patient serologically for at least 3 months. Patients with syphilis should receive adequate specific anti-syphilitic therapy with an appropriate antibiotic.
Trobicin is contraindicated in patients previously found hypersensitive to it.

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Sterile Trobicin (spectinomycin hydrochloride) —For Intramuscular Injection:
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An aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria gonorrhoeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between spectinomycin and penicillin.

Indications: Acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

Contraindications: Contraindicated in patients previously found hypersensitive to spectinomycin.

Warnings: Not indicated for the treatment of syphilis. Antibiotics used to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Patients should be carefully examined and monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected.
Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautians shauld be observed with atopic individuals.
Clinical effectiveness should be manitored ta detect evidence af develapment of resistance by *N. gonorrhoeae*.

Adverse reactions: The following reactians were abserved during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dase subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemaglabin, hematacrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single- and multiple-dase studies in normal volunteers, a reduction in urine autput was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25° C and use within 24 hours after reconstitution with diluent.

Male—Inject 5 ml intramuscularly for a 2 gram dose. Patients with ganarrheal practitis and patients being re-treated after failure of previous antibiatic therapy should receive 4 grams (10 ml). In geagraphic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.

Female—Inject 10 ml intramuscularly for a 4 gram dose.

How supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Recanstitution yields 5 and 10 ml respectively with a concentration of 400 mg spectinomycin per ml (as the hydrochlaride). For intramuscular use anly.
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Caution: Federal law prohibits dispensing without prescription.
For additional product information see your Upjohn representative or consult the package insert.

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† For patients with gonorrheal proctitis and for patients in geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams is preferred.

Appeals Court Rules for Hospital in Dispute

By C. R. Shelton, Detroit

In September, 1972, *Michigan Medicine* carried an article concerning a civil lawsuit then on appeal in the Michigan Court of Appeals involving a physician's claim that he was denied due process in various proceedings which terminated his staff privileges at a Detroit-area non-profit private hospital. The case was filed against the hospital and five physicians who served on the principal review committee. It was particularly interesting because of the far-reaching effects it could have on physician-hospital relationships.

Recently the Court of Appeals ruled that there were no procedural or legal errors that would require reversal of the Wayne County Circuit Court, and therefore affirmed the judgment in favor of defendants. In so doing the Court of Appeals approved the trial court's conclusions that due process standards had to be observed in private hospital proceedings which limit or alter physician staff privileges but that, in this case, such due process standards were adequately applied.

The suit is now on Application for Leave to Appeal to the Michigan Supreme Court. That Court has the option of either hearing or declining to hear the Appeal. If it declines, the decision of the Court of Appeals will be final.

Prior to his demotion, suspension and subsequent dismissal, the plaintiff served on the staff of the hospital in question. In his lawsuit he claimed — in part — that he was denied due process; that he had a certain contractual pledge agreement with the hospital, the terms of which were that in consideration of his promise to pay the hospital $3,000, he was promoted to and would remain on active staff status; and that the five individual defendants conspired against furtherance of a plan to exclude competition from the hospital and for their own personal and economic motives with the intent and effect of interfering with his advantageous business relationships.

The defendants countered that the plaintiff had been demoted, suspended and dismissed because of deficiencies in medical record keeping, non-attendance at staff meetings, plus deficiencies in patient care; he had failed to exhaust his administrative remedies; he was not denied substantive or procedural due process; the hospital is private, controlled by a privately elected board of trustees, which in its discretion may grant or deny hospital privileges to licensed physicians; the actions of the five physicians — members of the hospital's Credentials and Professional Standards Committee — do not constitute an attempt to establish and maintain a monopoly of the medical profession; and that the plaintiff is not entitled to be reinstated by reason of his pledge.

Oakland County Unit Studies Member Opinions

A majority of Oakland County physicians agree with the MSMS position on Professional Standards Review Organization activities according to results of a survey of members conducted by the board of directors of the Oakland County Medical Society.

In the tally of responses to the May 15 survey, 57.9 per cent of those replying said the medical profession should "Take every opportunity to state our objections to the PSRO law in its present form but move ahead to establish a regional PSRO structure in case we cannot modify the law." Of respondents, 23.6 per cent said physicians should oppose the law in every way legally possible and make no effort to participate in the establishment of PSRO in Oakland County, while 17.3 per cent said physicians should cooperate fully.

In another section of the survey, OCMS members considered a proposal to permit each major hospital to select one member for the county society board. Of respondents, 41 per cent agreed that hospital staff representation should be provided, while 55.7 per cent reported satisfaction with the present board structure.

Results of the survey, which also covered administrative questions and member services, were reported by Edwin M. Knights, MD, OCMS president, in the June issue of the society's *Bulletin*.

Welcome to Portland, Oregon for the 28th Clinical Convention

November 30-December 4, 1974

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Huldrick Kammer, M.D., Chairman
Council on Scientific Assembly

For further details, write:
Circulation & Records Dept.
American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610

The Role of the Detail Man

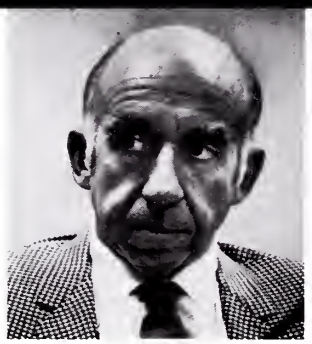
Opinion & Dialogue

Dr. Willard Gobbell
Family Physician
Encino, California

"I may be prejudiced, but I am very much in favor of the detail men I meet. Most of them are knowledgeable about the drugs they promote and can be a great help in acquainting me with new medication."

Family Physician's Perception

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most of the men who visit me regularly and they in turn have become aware of my particular interests and the nature of my practice. They, therefore, limit their discussion as much as possible to the areas of interest to me. Since I usually see the same representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date information about his products.



Dr. Jeremiah Stamler
Chairman
Department of Community Health and Preventive Medicine, and Dingman Professor of Cardiology
Northwestern University Medical School

"In the total picture of dealing with health problems in this country there is a potential for detail men to play a meaningful role."

The Positive Influence

My contact with representatives and salesmen of the pharmaceutical industry is the type of contact that people in a medical center, research people, and academic people have and that's in all likelihoc on a somewhat different level from that of the practicing physician.

Let me touch on how I personally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be—and at times actually are—disseminators of useful information. They could consistently serve a real educational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets—some of it scientifically sound and therefore truly useful—as well as some excellent films produced by the pharmaceutical industry. When they function in this

Is He a Source of Information?

Yes, with certain reservations. The average sales representative has a great fund of information about the drug products he is responsible for. He is usually able to answer most questions fully and intelligently. He can also supply reprints of articles that contain a great deal of information. Here, too, I exercise some caution. I usually accept most of the statements and opinions that I find in the papers and studies which come from the larger teaching facilities. It goes without saying that a physician should also rely on other sources for his information on pharmacology.

Training of Sales Representatives

Ideally, a candidate for the position as a sales representative of a pharmaceutical company should be a graduate pharmacist who has a questioning mind. I don't think this is possible in every case, and so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

---

capacity they are indeed useful; particularly in the fact that they disseminate broadly based educational material and serve not just as "pushers" of their drugs.

The Other Side of the Coin

Obviously, the pharmaceutical companies are not producing all this material as a labor of love—they are in the business of selling products for profit. In this regard the ambitious and improperly motivated sales representative can exert a negative influence on the practicing physician, both by presenting a one-sided picture of his product, and by encouraging the practitioner to depend too heavily on drugs for his total therapy. In these ways, the salesman has often distorted objective reality and undermined his potential role as an educator.

The Industry Responsibility

Since the detail man must be an information resource as well as a representative of his particular pharmaceutical company, he should be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.*, the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

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Centennial Year

Saginaw Hospital Marks First Hundred Years, Plans for Future Expansion, Progress

By Virginia Carter
Saginaw

St. Mary's Hospital was founded on Aug. 22, 1874, in Saginaw, primarily to serve the lumberjacks, rivermen and employees brought to the area by the boom of the lumbering industry.

The Rev. Francis Van der Bom, pastor of St. Mary's Church, headed a committee to raise $1,500, the amount needed to lease a 15 room building and furnish a hospital. Four Daughters of Charity came to Saginaw from Emmitsburg, Md., to operate the hospital.

St. Mary's Hospital had what might be the first hospital insurance plan in operation in an American hospital. Money was very scarce, so starting in 1879 the sisters, in pairs, visited all of the lumber camps to sell hospital tickets or certificates for $5 each to the lumberjacks, rivermen and sawmill employees. This hospital insurance plan guaranteed the purchaser hospital care for one year from the date purchased, in case of accident or illness (contagious disease, particularly smallpox, excepted). The $5 payment included surgical and medical attendance, nursing care, room and board. No patient was admitted under the influence of liquor, nor would those injured while in that condition be accepted.

Support 'Good Works'

The number of tickets purchased was so great, and the percentage requiring hospital treatment so small relatively, that the amount received enabled the hospital to carry on their good work. This was an important "partial support" for the hospital. The hospital's annual report in 1887 stated:

"Our ticket system has proved a merciful provision for laboring men and those without homes, who, in case of accident or sickness will be provided with surgical and medical treatment, nursing and board, without which many of them would be thrown into almshouses or poorhouses if not supported by public or private charity. We would, therefore, suggest to all manufacturers, mill and lumber firms, railroad corporations, and all others employing men to insist that they all are provided with Hospital Tickets."

The Hospital expanded with building programs in 1875, 1891, 1926, 1961 and 1971. The bed capacity went from 15 in 1874 to 278 in 1971.

The admissions over the last 100 years total nearly 400,000, with 45,000 newborns welcomed. Personnel increased from original four sisters to 846.

Recent Progress

The first cobalt 60 machine in the Saginaw area was installed in St. Mary's in 1961. The hospital

(Continued)

Mrs. Carter is community relations director for St. Mary's Hospital, Saginaw, and helped coordinate the hospital's year-long centennial celebration that concludes this month. Frederick J. Cady, MD, of Saginaw, chaired the hospital centennial committee which presented a series of events including a nuclear medicine day for physicians.

MSMS joins in the centennial tribute by publishing two scientific articles by physicians from the St. Mary's Hospital staff in this issue of Michigan Medicine. *Two more scientific articles by St. Mary's staff members will be presented in the September issue.*

ST. MARY'S HOSPITAL EAST SAGINAW, MICH
East Saginaw, Mich., December 17 1885
Certificate of St. Mary's Hospital,
OF EAST SAGINAW, MICHIGAN.
THIS CERTIFICATE, which is not transferable, entitles the holder,
Mr. Peter Coney
On the payment of Five Dollars ($5.00) during one year from date, in case of accident or sickness to the free use of the Wards of ST. MARY'S HOSPITAL during the time of his sickness, (contagious diseases excepted) including surgical and medical attendance, nursing and board.
In admission, no distinction is made regarding creed or country. These Certificates are not sold only to those in good health. All the Certificates will be stamped with the Seal of St. Mary's Hospital. None admitted while under the influence of liquor, nor injuries received while in that condition.
The following prominent Physicians and Surgeons constitute the Staff of Hospitals
DR. H. WILLIAMS, DR. L. W. BLISS,
DR. J. S. WHITE, DR. O. P. BARBER,
DR. W. L. DICKINSON, DR. J. S. ROUBE,
DR. W. F. MORSE.
Patrick Cahey Agent.

What was perhaps the first pre-payment plan for health care in the nation began in Saginaw in 1879 when the Daughters of Charity who operated St. Mary's Hospital began selling hospital tickets of the sort shown above providing one year's hospital care for $5. Surplus income was used to finance charitable activities. The hospital's year-long centennial celebration concludes this month.

has approved Schools of Medical Technology and Histology and provides clinical facilities for Delta College Schools of Nursing and Radiology. The hospital is also a member of Saginaw Cooperative Hospitals, Inc., an educational program for interns and residents.

Recent services added to the hospital include an alcoholism counseling program and a special procedures room for use in heart catheterization procedures. A drive is now under way to raise funds for a burn unit.

Plans for the future include construction of a satellite hospital on 33 acres of property recently purchased by the hospital adjacent to Saginaw Valley College.

James E. Richardson heads St. Mary's Hospital today. He became the first lay administrator in 1970.

MICHIGAN DEPARTMENT OF PUBLIC HEALTH

Monthly Surveillance Report

Cases of Certain Diseases
Reported to the Michigan Department of Public Health
For the four-week period ending June 28, 1974

	1974 This 4-Week Period	1973 Same 4-Week Period	1974 Total To Above Date	1973 Total Same Date	Total Cases for 1973
Rubella	206	311	1,091	1,698	2,001
Cong Rubella Syndrome	0	0	0	1	4
Measles	259	738	1,820	4,132	4,552
Whooping Cough	8	5	28	39	86
Diphtheria	0	0	0	0	0
Mumps	838	433	5,134	3,751	5,042
Scarlet Fever & Strep Sore Throat	2,014	1,343	24,090	13,127	24,467
Tetanus	0	0	1	0	2
Poliomyelitis (paralytic)	0	0	0	0	0
Hepatitis	263	257	1,937	1,951	3,872
Salmonellosis (other than S typhi)	64	44	524	294	795
Typhoid Fever (S typhi)	1	0	3	6	14
Shigellosis	102	48	524	285	623
Aseptic Meningitis	7	13	55	71	434
Encephalitis	4	20	28	84	163
Meningococcic Meningitis	1	6	28	32	54
H Influenza Meningitis	13	14	67	66	89
Tuberculosis	103	110	689	821	1,380
Syphilis	207	367	1,510	2,274	4,328
Gonorrhea	2,344	2,129	15,460	13,812	31,128

Information can be supplied by the local health department on the local incidence of disease.

Maurice S. Reizen, MD, Director
Michigan Department of Public Health

Scientific Articles

Management of Thermal Injuries in Community Hospitals

By Syed Saleem Akhtar, MD, Saginaw

Burns are an ever present problem. Thermal injuries frequently cause disability, disfiguration and death in youngsters. Extensive burns are catastrophic injuries — catastrophic in the overwhelming insult to the patient, catastrophic in their psychological aspects and catastrophic in the cost and suffering to the family involved.

Data from the National Health Survey for 1957 to 1961 show that the average number of burn injuries annually is 1.9 million. Of these, 937,000 are actively restricting injuries and 268,000 are classified as severe disabling injuries. In 1962 the U.S. Department of Health, Education and Welfare Public Health Services listed 7,645 deaths due to accidents caused by fire and explosion of combustible material and 849 deaths caused by electrical currents.[1] During that same year the number of deaths per 100,000 population caused by fire was 4.1. Males outnumbered females 4,421 to 3,293.[2]

All patients with burns serious enough to require hospitalization require some level of specialized treatment. All burn victims have lost some of the protective and regulatory functions of their skin and are thereby susceptible to infections, fluid loss, metabolic disorders and other complications. A considerable amount of time and attention is required to avoid or control these complications. It is estimated that the average length of hospitalization for patients with skin burns is 18 days, which is 80 per cent higher than the average length of hospitalization for all types of injuries combined.[3]

The author is director, Burn Service, St. Mary's Hospital, Saginaw, and a member of the American Burn Association.

Chances of survival for a 50-year-old person who has sustained approximately 40 per cent burns are only 38 per cent despite aggressive and definitive therapy.[4]

In the state of Michigan over 100,000 burn accidents occur each year; approximately 3,200 persons are hospitalized and about 400 die from these injuries. The scope of the problem in Michigan is seen in 385,000 days of disability and 13 million dollars in medical costs each year.

Role of Community Hospital

Approximately 90 per cent of thermal injuries are treated outside a burn care center,[6] as in community hospitals. The main purpose of presenting this article is to stress the need for better care of burn patients in community hospitals and also the establishment of burn care service. In St. Mary's Hospital, Saginaw, our burn team has tried to solve this problem in a number of ways and we will present briefly the management of burn patients in our hospital. This covers a period of approximately two and one half years, during which we had the opportunity of caring for the burn pa-

(Continued)

tients in the hospital and in the physician's office. *(Table I)*

Table I

Percentage of Body Burns
Treated From June 9, 1972, to Jan. 1, 1974

1 - 10%	183 patients
10 - 20%	46
20 - 40%	27
40 - 60%	5
60 - 80%	2
Over 80%	6
Total	269 Burn Patients

In the fall of 1971 we established a burn service in St. Mary's Hospital. Our burn team was composed of the following:

1. A general surgeon *(director of the burn service)*;
2. A physicians' team, composed of one of each of the following: internist, ophthalmologist, anesthesiologist, pediatrician and psychiatrist;
3. Nurses trained to work in this service;
4. One representative from Occupational Therapy and one from Nursing Service.

Total burn days care in 1970 *(before formation of the Burn Service)* was 470. This figure took a jump to 730 days care in 1971 and to 1,361 in 1972. This was clearly attributed to a better organized Burn Service in St. Mary's Hospital and good cooperation of all burn team members, which was responsible for satisfactory delivery of care to burned individuals. This attracted many burn patients from surrounding counties to our hospital. *(Table II)*

Table II

Report on Burn Patients Treated at St. Mary's Hospital
July, 1971, Through June, 1972

Days Care Given to Burn Patients	1,251 Days
Average Length of Stay, All Patients	16.9 Days
Average Length of Stay, Except Patients Admitted for Late Effects of Burns	18.8 Days

Saginaw is surrounded by many industrial complexes and we have treated 30 patients who sustained thermal injuries in industrial accidents. *(Table III)*

Table III

General Motors Patients Discharged From St. Mary's Hospital — March Through December, 1973

Number of Patients Treated	20
Days Care Given	472
Average Length of Stay	23.4 Days

Thermal Injuries From Other Industrial Complexes Discharged From St. Mary's Hospital — March Through December, 1973

Number of Patients Treated	10
Days Care Given	76
Average Length of Stay	7.6 Days

We not only are involved in treating acute thermal injuries, but also provide follow-up service for patients who need corrective or reconstructive procedures. *(Table IV illustrates this point.)*

Table IV

Burn Patients Discharged From St. Mary's Hospital
July — December, 1973

Degree	Pediatrics		Adults		Total	
	#	days	#	days	#	days
First Degree	0	0	0	0	0	0
Second Degree	11	124	16	168	27	292
Third Degree	12	313	16	343	28	656
Unspecified Degree	0	0	6	89	6	89
Complicated (all degrees)	0	0	1	10	1	10
Late Effect	11	83	9	84	20	169
Total	34	522	48	694	82	1216

Organization of Burn Service

In our opinion the following factors are of utmost importance in operating a smooth-running burn service in a community hospital:

1. A trained surgeon to direct the care of the burned patient. The foremost consideration in establishing a burn unit is the selection of an experienced and interested surgeon who has worked in a burn unit during residency days or, ideally, one who has spent at least a year in the management of burn injuries.[7] The University of Michigan is in the process of training surgeons who wish to specialize in burn treatment.[8] Presently only Brooke Army Medical Center has such a teaching program for surgeons who want to take care of burn patients.

(Continued on Page 457)

Tympanoplasty: *An Improved Technique*

By Nicholas P. Redfield, MD, Saginaw

History

Although attempts to do reconstructive ear surgery were not numerous early in this century, giant strides were made when Lempert described the one-stage fenestration procedure for individuals with conductive hearing losses secondary to otosclerosis. Subsequently, there was a flurry of activity in the area of reconstructive ear surgery with the development of the stapes mobilization procedure and finally, the stapedectomy.

Early attempts to do a Type I tympanoplasty for repair of perforations in the tympanic membrane date back several decades, and were first met with frustration and complications. In the early 1960's, William House in California described a technique in which he used canal wall skin as the grafted material, with initially good results. However, during long-term follow-up, he found that his canal wall skin grafts did not hold up well, and that he had a high long-term breakdown rate in his tympanoplasties, bringing the total survival rate of his grafts to less than 80 per cent.

Cody[1] reported on an extensive series of cases from the Mayo Clinic, involving over eight hundred patients, in which several types of tympanoplasties were performed. He found that the most successful group of tympanoplasties was that in which a layer of fascia was used, the first layer being placed medial to the tympanic membrane and the second being placed lateral to the tympanic membrane. He reported an initial take rate of 88 per cent, but found that over the long term, between six months and six years, the take rate decreased by approximately 3 per cent in the different categories of surgery which he reviewed. I had the good fortune to study under Doctor Cody and have developed what I consider an improvement and a modification of his technique, which has yielded in my relatively inexperienced hands, an improvement to 96 per cent graft take rate.

Technique

The technique involves the use of general anesthesia, which is supplemented with an injection of Xylocaine 0.5% with epinephrine 1:200,000 into the ear canal and the postauricular area to decrease bleeding. A postauricular incision is made down to the temporalis fascia superiorly and down to the mastoid cortex just at the posterior edge of the ear canal. Temporalis fascia, approximately the size of a quarter or larger, is taken and put out to dry under a warm lamp. The periosteum is elevated off the posterior ear canal wall down to the level of the annulus, and then the periosteum is elevated off the superior and inferior canal wall and down to the level of the annulus. The anterior canal wall skin is left in place and the squamous epithelium is elevated off the remnant of the tympanic membrane over its entire surface. The anterior canal wall skin is elevated away from the tympanic membrane for a distance of two to three millimeters. If exposure is difficult in the anterior sulcus, posterior lateral bony ear canal wall is removed to increase visibility in the anterior sulcus. On occasion, a mastoid cell is entered, but this has had no adverse affects.

Following removal of the squamous epithelium, the medial surface of the tympanic membrane is scraped and denuded of its mucosa as completely as is possible, using a sickle knife or a Tabb knife. Following this, the temporalis fascia, which should be dried and quite firm, is shaped so that the first piece of fascia will go through the tympanic membrane perforation and behind the malleus handle into the anterior portion of the middle ear, if the perforation will allow this. Usually, several pieces of Gelfoam impregnated with Cortisporin Ointment are placed medial to the anterior piece of fascia to hold it in contact with the medial surface of the tympanic membrane. The posterior portion of the first graft is placed lateral to the posterior remnants of the tympanic membrane, extending onto the posterior canal wall.

(Continued)

The author is adjunct professor of otolaryngology, Central Michigan University, and assistant clinical professor of otolaryngology, Michigan State University. He is on the staff of St. Mary's Hospital, Saginaw.

SAINT MARY'S HOSPITAL
1874
1974
SAGINAW MICHIGAN

A second piece of temporalis fascia is placed lateral to the entire tympanic membrane and lateral to the first fascia graft posteriorly. The anterior edge is placed into the anterior sulcus and occasionally rolled two to three millimeters onto the anterior cony canal wall. This second piece of temporalis fascia is usually large enough so that it covers the pars flaccida area. In the event that there is absolutely no anterior remnant of the tympanic membrane, I scrape the mucosa off the lateral wall of the anterior middle ear and extend the temporalis fascia graft into the posterior section of the eustachian tube.

The ear canal wall skin is then placed back in its normal position and held in place with Gelfoam impregnated with Cortisporin Ointment, and the postauricular incision is sutured. Care, of course, must be taken during the suturing not to dislodge the grafts out of their positions.

Results

The records of all patients who had tympanoplasties were examined, and those patients who had primary tympanoplasties without concurrent mastoidectomy were included for consideration in this study. The total number of cases was 79. Three people had no follow-up. Fifty-four patients were operated on using the post-auricular sandwich graft technique previously described. Initially there were 51 successes and three failures. However, one of these failures spontaneously closed within six months postoperatively and is considered a success. None of the patients who has come back for follow-up care has had spontaneous degeneration of the graft. There are, then, 52 successful tympanoplasties and two failures in those patients on whom a postauricular sandwich graft was used. As mentioned, there were no delayed spontaneous failures, but one patient did have a perforation secondary to trauma.

Of those patients in whom other techniques were used, a total of 23 patients was done. Eighteen were initially successful; five were initially failures. Of those five who were initial failures, two had subsequent closure by cauterization of their remaining perforations using trichloroacetic acid, leaving three permanent failures. There were no patients in this group who had subsequent long-term spontaneous perforation, and some of them have been followed for as long as four years.

Discussion

This operator has done less than 100 tympanoplasties to date, and it is my feeling that success rates of over 95 per cent in the hands of a relatively inexperienced surgeon indicate that the procedure has potential merit. My previous graft take rate had been approximately 80 per cent, and it is doubtful that such an improvement is due solely to the technical improvement of the operator.

One explanation for the improved success rate with this technique is the fact that the blood supply to the lateral graft is from two highly vascular sources, namely, the anterior canal wall skin and the posterior canal wall skin. Certainly this offers better blood supply than one would expect by placing a piece of fascia on a relatively avascular tympanic membrane.

A second advantage of this technique is that variations in air pressure within the middle ear relative to the outside environment are not likely to dislodge the grafts out of place in such a way that they would remain so permanently. The first piece of temporalis fascia has its inferior superior diameter equal to or slightly larger than the perforation of the tympanic membrane. This, then maintains the superior inferior position of the graft to some degree, and further maintenance of the original positioning is obtained by using Gelfoam in the middle ear on the medial surface, and by having the second piece of temporalis fascia overlying this. Negative pressure in the middle ear secondary to absorption of middle ear contents is not likely to pull both grafts away from the tympanic membrane. If the first graft is pulled away from the tympanic membrane in its anterior position, the second graft will remain in contact in the anterior position. Positive pressure in the middle ear when finishing the operation, or due to other causes such as bleeding, is readily compensated for by permitting the escape of blood or gases through the posterior margin of the perforation beneath the first graft. This, then, apparently leaks out above and below the graft and comes out the ear canal, forcing the anterior portion of the graft into contact with the anterior medial surface.

The problem of lateralization, which has been troublesome with lateral placement of grafts, has been completely eliminated in this series, at least as concerns the anterior sulcus, because of the second graft in the middle ear. I have had one or two grafts which have lateralized from the inferior-most portion of the malleus handle when the perforation was not heart shaped enough to permit the first graft placement to be medial to the malleus handle.

The major disadvantage of this technique at this time is a high incidence of graft cholesteatoma. This problem is being studied currently.

Summary

A tympanoplasty technique is presented which has reduced the graft failure rate from over 15 per cent to less than 4 per cent. Explanations for this improved success rate are discussed, and a comparison with the Mayo Clinic series is made.

Reference

1. Cody DTR, Taylor WF: Tympanoplasty: Long term results. *Ann Otol* **82**:538-46, 1973.

The Relationship Between Thyroid Function and Obesity

By Joel I. Hamburger, MD, FACP, and Donald A. Meier, MD, Southfield

Introduction

That hyperthyroid patients lose weight and hypothyroid patients gain weight is accepted medical dogma. From these axioms it is relatively simple to derive the further conclusions that hypothyroidism may be an important contributing factor to the production of obesity, and that treatment with thyroid hormone will not only correct the hypothyroidism but the obesity as well. Therefore, it is not surprising that overweight patients are frequently convinced that their problem is really caused by abnormal thyroid function. Most physicians are aware by now that the vast majority of overweight patients simply eat more than they need, and standard textbooks of thyroidology decry the administration of thyroid hormone for obesity. Nevertheless, screening the obese patient for hypothyroidism is considered standard medical practice,[1,2] and recent reports again suggest a possible role for thyroid hormone in obesity.[3,4] However, for 98 consecutive patients referred for thyroid evaluation for whom the presenting complaint was obesity, only six had hypothyroidism, and two had subnormal functional reserve (diagnosed on the basis of marginal baseline functional indices, and a subnormal response to TSH testing). Therefore, it seemed appropriate to reassess critically the relationship between thyroid function and obesity.

Material and Methods

The patients studied were from those referred to the Northland Thyroid Laboratory for evaluation of thyroid problems, including thyroid dysfunction, structural disorders only, disorders of both structure and function, and no thyroid disease.

For 100 consecutive patients with untreated primary hypothyroidism, 100 euthyroid patients matched for age and sex with the hypothyroid patients, 400 consecutive hyperthyroid patients and for 100 consecutive euthyroid patients whose presenting complaint was obesity, the height, weight, deviation of weight from normal body weight (for the sex and height) and the per cent deviation from normal weight were determined. The normal weight values were obtained from standard textbooks.[5,6]

The change in weight after correction of hypothyroidism and hyperthyroidism was then determined, and finally the serum thyroxine iodide (T_4D) concentration for lean and obese hypothyroid and hyperthyroid patients was compared to ascertain whether the differences in weight might relate to a difference in severity of thyroid dysfunction.

The T_4D was performed by the competitive binding radioassay method, using the Abbott Laboratory resin T_4 kit, and expressing the results as T_4 iodide (NR 3.0-6.5μg%).

Table 1

Age, Sex Distribution of Hypothyroid, Euthyroid, Hyperthyroid, and Obese Patients

Age Yrs.	Hypothyroids & Euthyroids		Hyperthyroids		Obesity	
	M	F	M	F	M	F
< 10	0	1	0	2	0	3
10-19	0	7	7	24	6	18
20-29	1	7	11	86	5	31
30-39	1	19	17	73	5	17
40-49	3	14	14	63	0	15
50-59	4	25	12	43	0	0
60-69	2	9	5	27	0	0
70+	1	6	2	14	0	0
Total	12	88	68	332	16	84

Results

Table 1 gives the age and sex distribution for the four groups of patients studied. Note that the hypothyroid and euthyroid patients are identical since euthyroid controls were selected (of course without prior knowledge of their weight) to match the hypothyroid patients in age and sex. The usual female to male preponderance by a factor of about 5 can be seen in all groups. The obesity patients tended to be younger than those with thyroid dysfunction.

(Continued)

From the Northland Thyroid Laboratory, Southfield

Table 2

% Deviation from Normal Weight for Hypothyroid, Euthyroid, Hyperthyroid and Obese Patients

% Deviation from Normal Weight	Hypothyroid		Euthyroid		Hyperthyroid		Obese	
−21 to −30	0	15	1	25	14	185		
−11 to −20	6		4		66			
− 1 to −10	9		20		105			
− 0 to +10	26	85	17	75	96	215	2	100
+11 to +20	24		18		61		15	
+21 to +40	22		25		45		30	
+41 to +60	11		8		10		21	
+61 to >+100	2		7		3		32	
No Pts	100		100		400		100	
Mean % Dev (±SD)	+17.2(±22.3)		+17.3(±23)		+4.2(±18.51)		+50.2(±29)	
Range % Dev	−18 to +101		−23 to +81		−29 to +83		+8 to +151	

P=0.9 for Hypo vs Eu

Table 2 shows the per cent deviation from normal weight for the four groups. Although the mean per cent deviation for hypothyroid patients is indicative of overweight, it is strikingly similar to that for the euthyroid controls. Furthermore, to our surprise, the mean per cent weight deviation from normal even for hyperthyroid patients indicated a tendency to overweight. This observation was made initially on the basis of only 100 consecutive patients, and we wondered if it might represent some unusual selection. We therefore decided to study an additional 300 patients so that there might be no doubt. The results were essentially the same. The data for euthyroid patients whose presenting complaint was obesity is provided simply to indicate that they were even more obese than the controls or hypothyroid patients.

Table 3 shows the change in weight observed after correction of hypothyroidism for the 27 patients available for reevaluation. Although there were more losers than gainers, and the mean decrement of losers exceeded the mean increment of gainers, it is clear that one cannot assure the hypothyroid patient that restoration of thyroid function to normal will necessarily be accompanied by significant weight loss.

Table 4 compares for hyperthyroid patients the changes in weight in the three months preceding treatment, as reported by the patient on history, and the changes in weight observed after correction of hyperthyroidism, segregated for lean (per cent deviation of weight from normal, -11% or greater) and obese (per cent deviation of weight from normal, +21% or greater). It can be seen that 22 of 25 lean hyperthyroid patients had lost weight in the three months prior to treatment, and only one had gained; whereas 20 gained after restoration to the euthyroid state. Of the 17 obese hyperthyroid patients, five had gained in the three months prior to treatment, two of whom lost after being restored to the euthyroid state. An additional five obese hyperthyroid patients who had lost weight before treatment, lost further after being restored to the euthyroid state. Thus it would seem that changes in weight for the obese hyperthyroid patients correlated less well with changes in thyroid function than was the case with the lean hyperthyroid patients.

Table 3

Change in Weight After Successful Treatment of Hypothyroidism

Change	No.	Range (lbs)	Mean
Increased	10	1-10	4.7
Decreased	16	1-20	6.8
No change	1		

Table 5 correlates the T_4D values and per cent weight deviation from normal for lean and obese hyperthyroid and hypothyroid patients. The

Table 4

Change in Weight, Lean and Obese Hyperthyroids, After Successful Treatment

Δ Wt in 3 Mo A Rx	Δ Wt from Rx to Euthyroid	Lean	Obese
Lost	gained more than lost	12	3
Lost	gained less than lost	8	2
Lost	lost more	2	5
Lost	no change	0	1
No change	lost	1	0
No change	gained	1	1
Gained	gained further	1	3
Gained	lost	0	2
Total		25	17

Table 5

Correlation of T_4D and % Weight Deviation for Hypothyroid and Hyperthyroud Patients

T_4D Values, μg%	Hyperthyroid Wt Deviation	Hyperthyroid Wt Deviation	Hypothyroid Wt Deviation	Hypothyroid Wt Deviation
(NR 3.0-6.5)	−11% or more (59 pts)	+21% or more (45 pts)	< normal (15 pts)	+21% or more (33 pts)
Mean	9.95	9.6	1.0	1.57
Range	6.9-13	6.4-13	0.5-2.9	0.2-3.4
SD	±2.08	±2.26	±0.7	±0.91
	P = 0.70		P = 0.50-0.40	

values are almost identical for the hyperthyroid patients, whether lean or obese. For the hypothyroid patients the more obese actually have higher mean T_4D values rather than lower, however, the differences were not statistically significant. Hence it would appear that differences in weight within the hyperthyroid and hypothyroid populations cannot be attributed to differences in relative severity of the thyroid dysfunction, at least as reflected by the T_4D values.

Discussion

The results of this study serve to reinforce our impression that obesity is not a reflection of hypothyroidism. The most surprising finding was the frequency of obese hyperthyroid patients. More hyperthyroid patients were overweight than underweight; almost 15 per cent were more than 20 per cent overweight. These obese hyperthyroid patients should be carefully instructed in a graded program of increasing caloric restriction which is adjusted to the regression of the hyperthyroidism as the effects of treatment become manifest. It is important to maintain adequate protein intake to promote rebuilding of the muscular tissue which so characteristically suffers in hyperthyroidism.

The pattern of weight deviation from normal observed for hypothyroid patients coincided almost exactly with that for age and sex matched euthyroid controls. The changes in weight which accompany treatment of hypothyroidism are not consistent and neither solely nor directly relate to thyroid hormone administration. Although the data do not eliminate the necessity for considering a diagnosis of hypothyroidism for obesity patients, if obesity is the only indication for concern the probability of hypothyroidism is small. One should search for clinical manifestations more specific for hypothyroidism prior to ordering extensive testing. Furthermore, the physician should be cautious in his prognosis for weight loss in response to thyroid hormone for the hypothyroid patient who happens also to be obese. The greater the obesity, the less likely that hypothyroidism plays a significant role in its development.

It still can be said: "You are what you eat!"

Conclusions

1. Patients with obesity seldom have hypothyroidism.

2. Patients with hypothyroidism may or may not be obese, but the pattern of per cent weight deviation from normal for the 100 hypothyroid patients studied was almost identical to that for age and sex matched euthyroid controls.

3. The changes in weight observed after treatment of hypothyroidism were variable, including both weight loss and weight gain.

4. Although many of the untreated hyperthyroid patients had lost weight in the months prior to diagnosis, some had gained, and almost 15 per cent were more than 20 per cent overweight at the time the diagnosis was established.

5. The changes in weight observed for obese hyperthyroid patients after treatment also were variable, including both weight loss and weight gain.

6. For both hyperthyroid and hypothyroid patients, extremes of per cent weight deviation did not reflect differences in severity of the thyroid dysfunction, at least as assessed by the T_4D test.

7. For obese patients, whether hypothyroid or hyperthyroid, thyroid function per se seems not to be the dominant factor in the weight fluctuations.

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PEOPLE

Dean P. Carron, MD, of Ann Arbor,

is the new president of the Michigan Psychiatric Society. Other officers for the coming year are Norman Rosenzweig, MD, of Detroit, president-elect; Garfield Tourney, MD, of Detroit, vice president; George F. Newman, MD, of Dearborn, secretary, and Elliot D. Luby, MD, of Detroit, treasurer. Serving as councilors are Hubert Miller, MD, of Southfield; Frederick F. Shevin, MD, of Birmingham; Raymond E. Buck, MD, of Detroit, and Albert J. Silverman, MD, of Ann Arbor. Kenneth E. Pitts, MD, of West Bloomfield, was chosen delegate to the American Psychiatric Association Assembly and Doctor Rosenzweig was named alternate delegate.

Daniel N. Finch, of Kalamazoo,

was elected president of the Michigan Hospital Association at the association's annual convention in June at Mackinac Island. He is administrator of Bronson Methodist Hospital in Kalamazoo. Richard Sejnost, administrator of Harper Hospital in Detroit, was chosen president-elect.

William James Fry, MD, of Ann Arbor,

has been named the first distinguished Frederick A. Coller professor of surgery at the University of Michigan Medical School. Funds for endowment of the chair were raised by the Frederick A. Coller Surgical Society, made up of former students of the famed surgeon, who was chairman of the U-M Department of Surgery for 27 years prior to 1957.

Mrs. Joan S. Guy, of East Lansing,

executive director of the Michigan Nurses Association, was elected to a two-year term as secretary of the American Nurses Association at its annual convention in San Francisco.

Cecilia Hissong, MD, of Dearborn,

was installed recently as president of the Michigan Academy of Family Physicians. Serving with Doctor Hissong for the coming year will be Robert W. Oakes, MD, of Harbor Beach, president-elect; George A. Dean, MD, of Southfield, vice president; Gordon Willoughby, MD, of Frankfort, secretary; Donald E. DeWitt, MD, of Holland, treasurer, and Roy J. Gerard, MD, of Saginaw, speaker of the house.

Kenneth H. Johnson, MD, of Lansing,

MSMS secretary, recently celebrated his 40th anniversary in medical practice. He was honored by colleagues, friends and patients at a reception June 29 in MSMS headquarters. Doctor Johnson, a past president of both MSMS and the Ingham County Medical Society, and a past speaker of the MSMS House of Delegates, was graduated from the University of Michigan Medical School in 1932. He completed his internship and a second postgraduate year at Lansing's Sparrow Hospital before establishing his family practice in the capital in 1934.

John M. Malone, MD, of Farmington Hills,

has been installed as president of the Michigan Society of Obstetricians and Gynecologists for 1974-75. Hermann A. Ziel, Jr., MD, of East Lansing, was chosen president-elect. Other officers are Donald T. Olson, MD, of Detroit, treasurer, and Robert G. Walkowiak, MD, of Detroit, secretary. Elected to the society's Council for two-year terms were Charles Aldridge, Jr., MD, of Grand Rapids; Robert H. Johnson, MD, of Rochester; Richard J. McMurray, MD, of Flint, and Louisa I. Piccone, MD, of Detroit.

Richard H. Meade, MD, of Grand Rapids,

is the author of *In the Sunshine of Life,* a biography of Dr. Richard Mead, 1673-1754, published in July by Dorrance & Company, Philadelphia. The subject of the biography, no relation to the author, is described in the preface as "probably the most erudite physician that England ever had." He established England's public health system. His patients included Sir Isaac Newton, King George II, Alexander Pope, Samuel Johnson and Robert Walpole and he was known as a collector of art and books. Michigan's Doctor Meade, past president of the American Association for Thoracic Surgery, also is the author of *A History*

of Thoracic Surgery and *An Introduction to the History of General Surgery.*

James G. Ravin, MD, and Ralph I. Fried, MD, of Ann Arbor,

are authors of an article on "Picasso, Velasquez and Dwarfs" appearing in the June 24 issue of *JAMA.* A letter by Edward J. Dranginis, MD, of Tecumseh, on "Death with Dignity" appears in the same issue.

Melvin L. Selzer, MD, of Ann Arbor,

has been named director of an Alcoholism and Drug Abuse Clinic to be established by the University of Michigan Department of Psychiatry at the U-M Medical Center. Doctor Selzer is professor of psychiatry at U-M. The clinic, which is to open next year with the aid of a federal grant of $120,000, will provide service to all patients who appear between 8 a.m. and 5 p.m. daily and also will have 24-hour referral service, Doctor Selzer said.

Herschel A. Shulman, MD, of Southfield,

has been elected vice president of the Michigan Diabetes Association. New board members, for three year terms, include Doctor Shulman, James J. Aiuto, MD, of St. Clair Shores; John B. Bryan, MD, of Royal Oak; Piero P. Foa, MD, of Detroit; J. Donald Hare, MD, of Kalamazoo, and Ralph Knopf, MD, of Ann Arbor.

Myron E. Wegman, MD, of Ann Arbor,

has been honored as the first recipient of the Walter P. Reuther Distinguished Service Award. The award, a medal carrying the likeness of the late United Auto Workers' president, was instituted to give recognition for community service. It was presented to Doctor Wegman at a banquet of the Southeast Michigan Comprehensive Health Planning Council. Doctor Wegman stepped down July 1 from his post as dean of the University of Michigan School of Public Health to devote himself to teaching and the study of international problems in public health.

Frederick Weissman, MD, of Detroit,

has been elected president of the Midwestern Association of plastic surgeons for 1974-75. Burns G. Newby, MD, of Southfield, was selected as secretary. Doctor Weissman is planning the 1975 annual meeting of the association to be held in April in Southfield.

Floyd Westendorp, MD, of Holland,

has been named associate professor and director of graduate psychiatric education for the Grand Rapids Area Medical Education Center. He will be establishing the first psychiatric residency program in Western Michigan under GRAMEC auspices. Doctor Westendorp formerly was director of Community Mental Health Services of Ottawa County in Holland.

Piero P. Foa, MD (left), of Detroit, receives a top AMA award for his exhibit prepared for the 1974 Scientific Assembly in Chicago. Robert H. Barter, MD, vice chairman of the AMA Council on Scientific Assembly, presents Doctor Foa with the Hektoen Gold Medal for exhibit on "Glucagon — Role in Physiology, Pathogenesis of Diabetes and Hypoglycemia, Therapy and Diagnosis: 50 Years of Research." Doctor Foa is on the staff of Sinai Hospital, Detroit.

Commentary

Medicine Must Take Responsibility for Monitoring Nuclear Development

By Gerald A. Drake, MD
Petoskey

When nuclear power was first announced, most of us were enthused about its potential. With the passage of time, however, more and more reasons for concern appear.

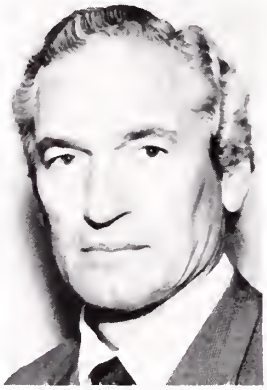
The February, 1974, issue of the *Bulletin of Atomic Scientists* carries an article which suggests an increase in leukemia in Australia from as little as 1 millirad of strontium-90 per year. Another article points up again the risk of blackmail using radioactive material.

A previously undetected leak from the Shippingport reactor could explain the presence of increased strontium-90 and cesium-137 in Pittsburgh milk for the period 1968 through 1972. The plant monitoring system was apparently inadequate.

Would Suspend Approval

The National Resources Defense Council has petitioned the Environmental Protection Agency and the Atomic Energy Commission to suspend approval of any facility handling plutonium or other radionuclides capable of forming "hot particles," pending final resolution of new standards. The hot particles study indicates that plutonium-239 standards are over 100,000 times too high. A single virus sized particle of plutonium-239 has been assumed to deliver a dose of only 0.3 millirems per year averaged over the entire lung. However, the minute area of tissue actually irradiated may receive as much as 4 million millirems per year. Present generation nuclear reactors produce and use some plutonium-239. With the development of the liquid metal fast breeder reactor we will have an economy greatly dependent on this highly toxic material.

Nuclear plant dependability has been disappointing. On Dec. 10, 1973, 13 out of 38 operable nuclear plants were shut down due to malfunctions



Dr. Drake

or accidents. Last year 32 plant months were lost due to public law suits and 229, seven times as many, lost through economic or technological failures.

Frank Baranowski, the Atomic Energy Commission's director of production and materials management, testified before the Joint Committee on Atomic Energy, on March 5, 1974, that the demand for uranium for U. S. reactors will exceed production capability from known resources within eight years.

Short Supply

Morgan Huntington, an engineer with United States Department of the Interior, states that the total energy input for mining, milling and enriching necessary low grade uranium will be greater than the ultimate energy output from the reactors. He concludes that the uranium shortage will lead many public utilities into bankruptcy.

In medical practice, we naturally consider it poor clinical judgement to use life threatening therapy for benign disease, especially when safer methods have not been tried. This could apply to nuclear power. For example, blood transfusions in

(Continued on Page 466)

Doctor Drake is a member of the MSMS Committee on Public and Environmental Health.

Socio-Economic

Relative Value Study Revisions: Part II

Here are revisions and additions to the radiology section of the 1973 Michigan Relative Value Study, prepared by the MSMS Bureau of Economic Information to update the study for 1974. Revisions for medicine and surgery were published in *Michigan Medicine* in July. Physicians may add the revisions to their copies of the RVS. Additional copies of the revisions are available from MSMS.

NEW NABSP PROCEDURE CODES

Effective 7/1/74

CPT	OLD MBS	NABSP	DESCRIPTION	P.C.	TOTAL
70015	None	7004E	Cisternography, positive contrast	8	20
70400	None	7045H	Orbitography, air or positive contrast	8	20
71036	7105	7105J	Fluoroscopic localization for needle biopsy of intrathoracic lesion, including follow-up films	5	10
72200	None	7226D	Sacro-iliac joints, less than three views	1.2	3
70010	7236	7233J	Myelography, posterior fossa	8	15
72290	7240	7240E	Discography, cervical	5	10
72290	7240	7241C	Discography, lumbar	5	10
73120	None	7290J	Hand (including fingers), minimum two views	1	2
73130	7290	7291H	Hand (including fingers), minimum three views	1.2	3
74010	7331	7333H	Abdomen, anterior-posterior and additional oblique views	1.6	4
74260		7342I	Duodenography, hypotonic	4	9
74270	7344	7344E	Colon, barium enema	4	9
74285		7347F	Colon, barium enema, high voltage technique for polyp study	4	9
74440		7373D	Vasography, vesiculography or epididymography	2	5
74725	7391	7391F	Abdomen for fetal age, fetal position and/or placental localization, single view	1.6	4
74770	7395	7397C	Intrauterine contrast for fetal study	4	8

Note: Relative value assigned to code numbers include supervision and interpretation only. Introduction procedures have additional relative values and a separate code number.

(Continued)

CPT	OLD MBS	NABSP	DESCRIPTION	P.C.	TOTAL
76500	8951	7400E	Echoencephalography, diencephalic midline, A-mode or echography thyroid, A-mode	1.6	4
76505		7401C	Echoencephalography, complete (diencephalic midline and ventricular size), A-mode or echography thyroid, scan B-mode	3	6
76510	7011	7405D	Echography, ophthalmic, A-mode or ophthalmic biometry, A-mode	4	8
76511 76512		7406B	Echography ophthalmic, with amplitude quantitation, A-mode or contact scan B-mode	6	12
76513 76514		7407J	Echography ophthalmic, immersion scan B-mode, immersion M-mode or ophthalmic biometry scan B-mode	8	15
76515		7408H	Echography ophthalmic, tomography, serial scan B-mode	15	30
76600 76630 76640	7552	7415C	Echocardiography, pericardial effusion M-mode, echography pleural effusion A-mode, or echography breast, A-mode	2.5	5
76610	7552	7416A	Echocardiography, cardiac valve(s), M-mode	3	6
76620 76645	7552	7417I	Echocardiography M-mode complete (7415C & 7416A combined, and chamber dimensions), or echography breast, scan B-mode	4.6	8
76625	7552	7418G	Echocardiography, limited, as follow-up or limited study (use only with 7417I, M-mode complete)	2	4
76710	7356	7425B	Echography, scan B-mode, hepatic	6	12
76720		7425B	gallbladder	6	12
76730	7362	7425B	renal	6	12
76740		7425B	pancreas	6	12
76750	7357	7425B	spleen	6	12
76770		7425B	retroperitoneal	6	12
76765		7425B	abdominal aorta	6	12
76700	7333	7425B	abdominal-complete survey study	6	12
76705		7426J	Echography, limited, as follow-up or limited study (use only with 7425B-scan B-mode, abdominal-complete survey study)	4	8
76760		7427H	Echography, abdominal aorta, A-mode	2.4	5
76780		7428F	Echography, urinary bladder, scan B-mode	4	8
76800		7435A	Echography, scan B-mode for pregnancy diagnosis	3	6
76810 76820 76830		7436I	Echography, scan B-mode for: fetal age determination (biparietal diameter), placental localization, molar pregnancy diagnosis	4	8
76815		7437G	Echography, scan B-mode for fetal growth rate (series of 7436I - fetal age determination)	2.4	5
76825 76835		7438E	Echography, scan B-mode for: pregnancy, complete (7435A, 7436I and 7437G combined), ectopic		

CPT	OLD MBS	NABSP	DESCRIPTION	P.C.	TOTAL
76850			pregnancy diagnosis, or pelvic mass diagnosis	6	12
76605 76635 76860 76960		7451H	Ultrasonic guidance, any area	By Report	
75750	7472	7470H*	Angiography, coronary, root injection	15	20
75752	7472	7471F*	Angiography, coronary, unilateral selective injection	15	20
75754		7472D*	Angiography, coronary, bilateral selective injection	15	20
75662		7477C*	Angiography, cervicocephalic, selective	15	40
75831		7480G*	Venography, renal selective, unilateral	7	12
75833		7481E*	Venography, renal selective, bilateral	10	19
75810	7482	7482C*	Venography, caval, inferior or superior, or splenoportography	5	10
		7483A*	Venography, caval, other than renal or spleen, selective (per vessel), add	2	5
75845		7486D*	Venography, azygos, selective or non-selective	6	10
		7488J*	Venography, sinus or jugular	6	10
75801	7489	7489H	Lymphangiography, extremity only, unilateral	4	15
75803	7490	7490F	Lymphangiography, extremity only, bilateral	5	18
75805	7489	7491D	Lymphangiography, pelvic/abdominal, unilateral	6	21
75807	7490	7492B	Lymphangiography, pelvic/abdominal, bilateral	9	25
	7568	7568I	Multidirectional microtomography	8	20
	7495	7569G	Serialography, additional	N	7
	7496	7570E	Cineradiography, additional	3.2	8
		7573I	Xeroradiography, additional	N	2

(Continued)

*Does not include biplane (7570E or 7497A), Cineroentgenography (7496C) or Serialography (7495E or 7569G) unless specified.

NEW NABSP PROCEDURE CODES
Effective 7/1/74

CPT	OLD MBS	NABSP	DESCRIPTION	P.C.	TOTAL
59000	4885 4886	4800I	Amniocentesis for diagnosis, abdominal	6	6
76000	7550	7550G	Fluoroscopy (limited to specific procedures as performed by a radiologist on a time basis	By Report	
78410	7876	7892C	Salivary glands	4	15
	7907	7929C	Dynamic flow studies, cerebral blood flow	5	15
	7908	7939B	Dynamic flow studies, cerebral blood flow and brain scan	13	35
78560	7907	7940J	Cerebral circulation study	6	15

DELETED NABSP CODE NUMBERS

NABSP	DESCRIPTION
9555D	Ultrasonography (echograms) A-scan, brain
9556B	Ultrasonography other areas or organs
9557J	Ultrasonography, B-scan
7332J	Abdomen, including PA chest
7360A	Kidney, ureter and bladder, single view
7361I	Kidney, ureter and bladder, multiple views
7465I	Intravenous angiocardiogram

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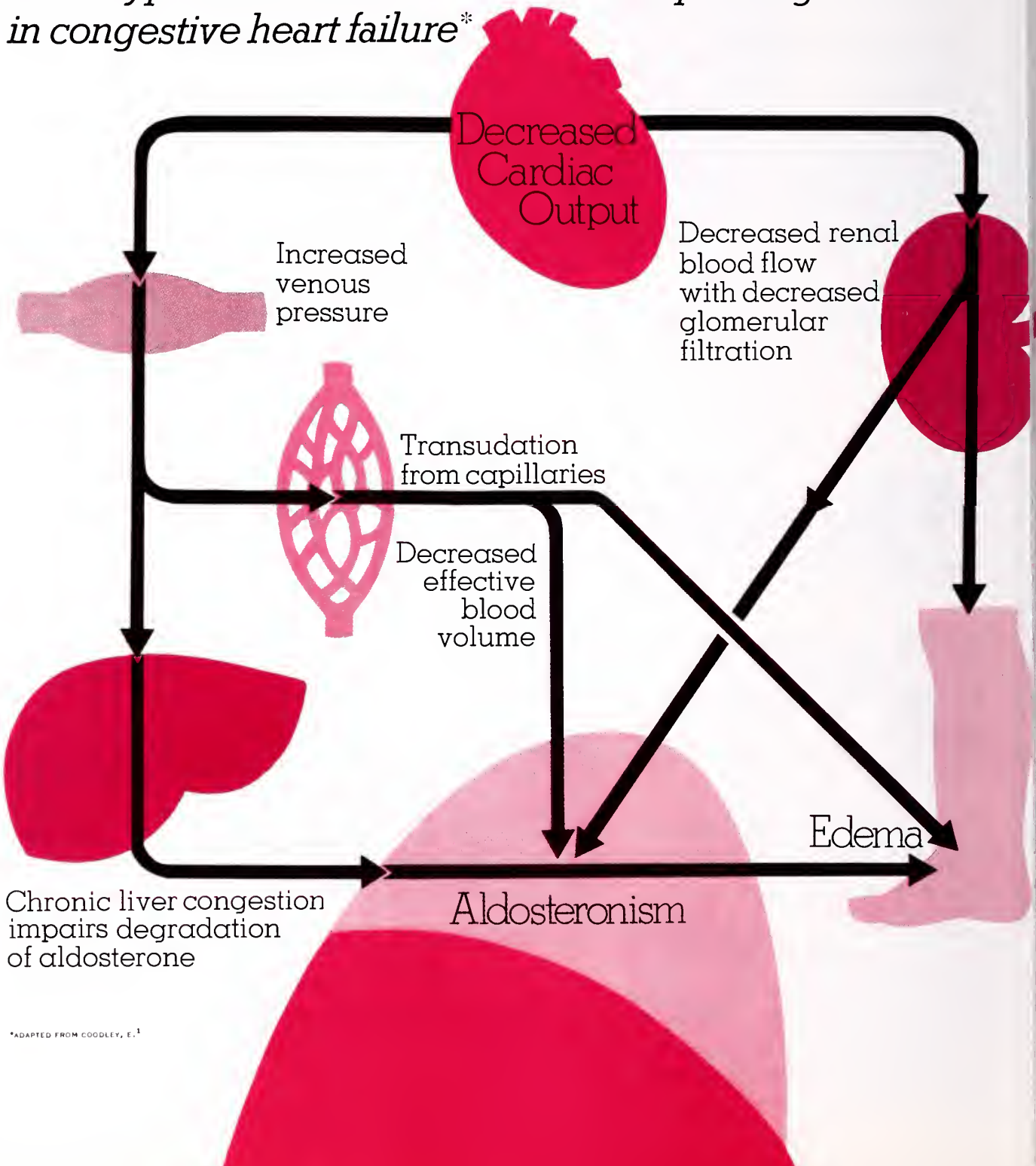

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2. As the basic daily diuretic with an "add-on" alternate-day-diuretic ("A.D.D." schedule)

- Can be administered daily as basic therapy with the additional agent (furosemide or ethacrynic acid) given every second or third day.
- Aldactone plus "A.D.D." schedule minimizes potassium deficiency and potentiates effect of "add-on" diuretic.[2]
- Avoids acute volume depletion and aldosterone rebound.[2]

3. As a daily diuretic in combination with a daily dose of a thiazide

- Permits daily additive diuretic effect while maintaining potassium balance.

Indications—Essential hypertension; edema or ascites of congestive heart failure, cirrhosis of the liver and the nephrotic syndrome, idiopathic edema. Some patients with malignant effusions may benefit from Aldactone (spironolactone), particularly when given with a thiazide diuretic.

Contraindications—Acute renal insufficiency, rapidly progressing impairment of renal function, anuria and hyperkalemia.

Warnings—Potassium supplementation may cause hyperkalemia and is not indicated unless a glucocorticoid is also given. Discontinue potassium supplementation if hyperkalemia develops. **Usage of any drug in women of childbearing age requires that the potential benefits of the drug be weighed against its possible hazards to the mother and fetus.**

Precautions—Patients should be checked carefully since electrolyte imbalance may occur. Although usually insignificant, hyperkalemia may be serious when renal impairment exists; deaths have occurred. Hyponatremia, manifested by dryness of the mouth, thirst, lethargy and drowsiness, together with a low serum sodium may be caused or aggravated, especially when Aldactone is combined with other diuretics. Elevation of BUN may occur, especially when pretreatment hyperazotemia exists. Mild acidosis may occur. Reduce the dosage of other antihypertensive drugs, particularly the ganglionic blocking agents, by at least 50 percent when adding Aldactone since it may potentiate their action.

Adverse Reactions—Drowsiness, lethargy, headache, diarrhea and other gastrointestinal symptoms, maculopapular or erythematous cutaneous eruptions, urticaria, mental confusion, drug fever, ataxia, gynecomastia, inability to achieve or maintain erection, mild androgenic effects, including hirsutism, irregular menses and deepening voice. Adverse reactions are infrequent and usually reversible.

Dosage and Administration—For **essential hypertension** in **adults** the daily dosage is 50 to 100 mg. in divided doses. Aldactone may be combined with a thiazide diuretic if necessary. Continue treatment for two weeks or longer since an adequate response may not occur sooner. Adjust subsequent dosage according to response of patient.

For edema, ascites or **effusions** in **adults** initial daily dosage is 100 mg. in divided doses. Continue medication for at least five days to determine diuretic response; add a thiazide or organic mercurial if adequate diuretic response has not occurred. Aldactone dosage should not be changed when other therapy is added. A daily dosage of Aldactone considerably greater than 75 mg. may be given if necessary.

A glucocorticoid, such as 15 to 20 mg. of prednisone daily, may be desirable for patients with extremely resistant edema which does not respond adequately to Aldactone and a conventional diuretic. Observe the usual precautions applicable to glucocorticoid therapy; supplemental potassium will usually be necessary. Such patients frequently have an associated hyponatremia—restriction of fluid intake to 1 liter per day or administration of mannitol or urea may be necessary (these measures are contraindicated in patients with uremia or severely impaired renal function). Mannitol is contraindicated in patients with congestive heart failure, and urea is contraindicated with a history or signs of hepatic coma unless the patient is receiving antibiotics orally to "sterilize" the gastrointestinal tract.

Glucocorticoids should probably be given first to patients with nephrosis since Aldactone, although useful for diuresis, will not directly affect the basic pathologic process.

For **children** the daily dosage should provide 1.5 mg. of Aldactone per pound of body weight.

References: **1.** Coodley, E.: Consultant 12: 106-107, 109, 111, 113, 115 (July) 1972. **2.** Thorn, G. W., and Lauler, D. P.: Am. J. Med. 53: 673-684 (Nov.) 1972.

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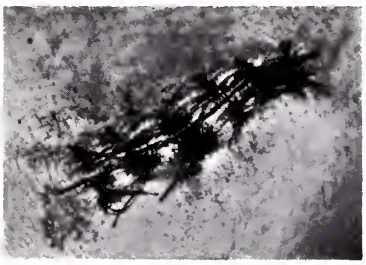

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2. Training of staff for the unit. The crux of good patient care lies in a well-trained burn nursing staff, especially in a community hospital where, in many cases, there is no house staff to assist and share the responsibility of the physician in charge. Facilities are available at the University of Michigan for special burn training of nurses. Nurses, after undergoing this training, are given the opportunity of performing procedures such as debridement, dressing changes and even fluid monitoring under supervision.

3. The establishment of and cooperation with other services such as: (a) Occupational Therapy, (b) Respiratory Care and (c) Social Services.

It is very important to have the services of well-trained and dedicated occupational therapists. A good therapist can work effectively from the first day in helping prevent contractures with active and passive movements, splinting and hydrotherapy.

A number of burn patients need respiratory care, especially those with inhalation injuries. Some of them need assisted breathing with a ventilator.

Many patients spend months in the hospital following thermal injuries and to boost their morale, as well as work out financial assistance for these prolonged stays, the services of a good Social Services worker is invaluable in backing up the medical management of the case.

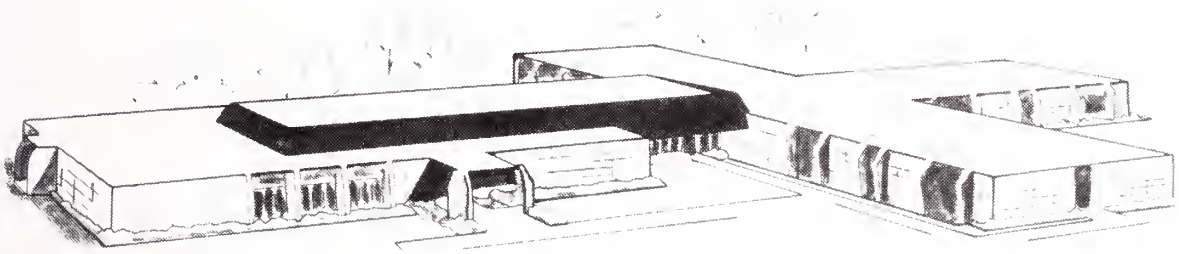
Conclusion

The care of a burn patient requires the services of dedicated physicians, nurses and ancillary staff, all with special training, who are willing to deliver first-rate care. In St. Mary's Hospital we have not yet achieved our final goal but we have provided care to almost 275 burn patients in the last 30 months with gratifying results.

References

1. Bull JP: Causes, prognosis and prevention of burns. *The Medical Press* **239**:205, 1958.
2. Vital Statistics, US Department of Health, Education and Welfare, 1962.
3. National Center for Health Statistics, vital and health statistics, hospital discharged and length of stay, *Public Health Service Publication No. 1000,* Series 10, No. 30.
4. Feller I, Crane K: Planning and designing a burn care facility, *Institute for Burn Medicine,* P.5.
5. Feller I, et al: *Mich Med* **71**:317, 1972.
6. Feller I, et al: *Mich Med* **71**:317, 1972.
7. Feller I, Crane K: Planning and Designing a Burn Care Facility. *Institute for Burn Medicine.* 16.
8. Feller I: Personal conversation.

FOREST VIEW PSYCHIATRIC HOSPITAL



Charles L. Callaway MD, Medical Director

Located on six beautifully wooded acres, *FOREST VIEW HOSPITAL* is Michigan's newest private psychiatric facility, specializing in short term intensive treatment. Comprehensive adjunctive therapy, including occupational and recreational therapy is emphasized. The prime goal of the hospital personnel is to aid the patient in coping with his illness and return him to community life as soon as possible. Licensed by the State of Michigan, Department of Mental Health, Accredited by the Joint Commission of Accredation of Hospitals, Participant in Medicare and Medicaid.

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Around Michigan

U.P. Medical Society Elects Dr. Brukardt

Herman R. Brukardt, MD, of Menominee, has been elected president of the Upper Peninsula Medical Society for the coming year. Serving with Doctor Brukardt will be Henry Barsch, MD, of Marquette, executive committee chairman, and John Pillote, MD, of Marquette, secretary-treasurer.

Doctor Barsch also is directing organizational activities of the Upper Peninsula Quality Assurance Association, which has been awarded a $45,300 Professional Standards Review Organization planning grant by the federal Department of Health, Education and Welfare.

Scientific programs at the recent U.P. Medical Society annual meeting stressed increasing patient involvement in treatment of cancer and heart disease.

Physicians attending the session also learned details of a new plan by Michigan State University's College of Human Medicine to train physicians in the Upper Peninsula. Donald Weston, MD, associate dean, said that the first ten students selected for the program will begin medical studies in September on the East Lansing campus, then continue first year programs in U.P. locations in January, 1975. After the first year, students will begin their studies in the U.P. he said.

The program, named the Modular Medical Education Program, offers "a tremendous opportunity for the U.P. in the training of medical skills," according to Raymond Hockstad, MD, MSMS Council member from Escanaba.

Clinical experience for the students will be provided in an ambulatory care center in Escanaba, in physicians' offices and public health facilities in Marquette and Escanaba and in community hospitals. Both MSU professors and practicing physicians will serve as the faculty.

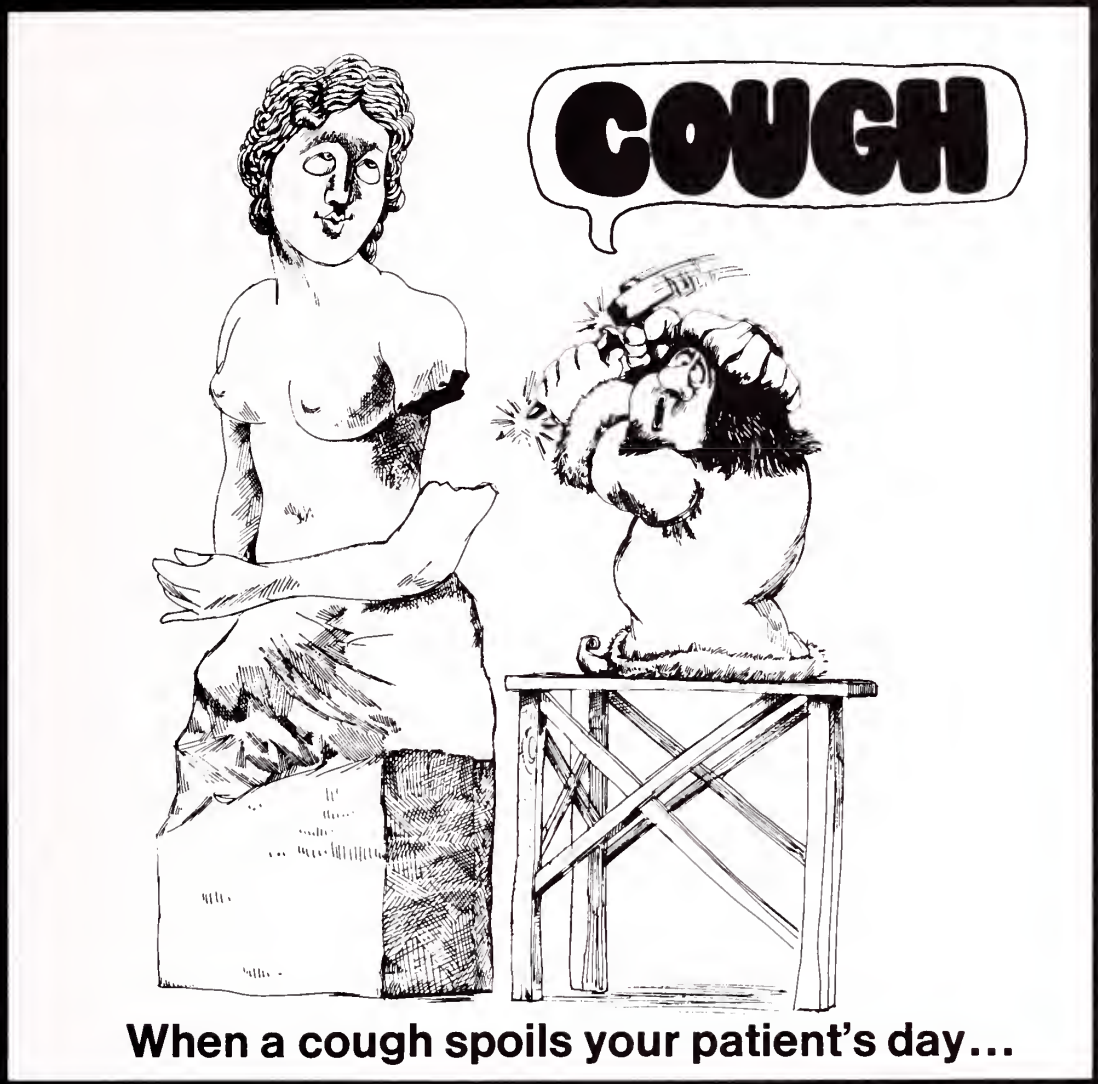
George E. Gullen, Jr., president of Wayne State University (left), and Robert D. Coye, MD, dean of the WSU Medical School, sign certificates for 69 physicians who have completed their programs in the WSU School of Medicine Affiliated Intern-Resident Program. The 69 completing internships or residencies are part of a total of 486 doctors who are participating in the ongoing program. This is the first year in which completion of the program has been recognized by WSU in the form of a certificate.

Health Council Issues New Opportunity Listing

The Michigan Health Council has issued a new Roster of Opportunities for physicians seeking to establish practice or make professional affiliations in Michigan. The roster has listings for every part of the state. Data includes type of specialty needed, community information and facts on available health care facilities and, in many cases, economic potential. In addition to listings for private practice opportunities, the roster offers information on posts such as those in college health centers.

The back cover of the roster carries a shaded map showing at a glance the ratio of primary care physicians to population in each Michigan county. Copies are available from the Michigan Health

(Continued on Page 460)



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Council, 712 Abbott Rd., East Lansing, Mich. 48823. Requests submitted to MSMS will be forwarded to the Health Council.

Symposium Will Honor Dr. Conn

A symposium in honor of Jerome W. Conn, MD, distinguished physician of the Veterans Administration, and University of Michigan distinguished professor of Internal Medicine, will be held Friday, Oct. 18, in the University Hospital Amphitheatre. Doctor Conn was head of the U-M Division of Endocrinology and Metabolism and director, Metabolism Research Unit, from 1943 to 1973.

Scientific papers will be presented by 15 physicians formerly associated with Doctor Conn as staff members or as trainees in endocrinology and metabolism. The papers to be presented will include aspects of the renin-angiotensin-aldosterone system, endocrine hypertension, calcium and parathyroid hormone metabolism, pituitary function and carbohydrate metabolism.

Each paper will be followed by open discussion. The morning session will begin at 8:30 and the afternoon session at 2. Lunch, by subscription, will be available in the private dining rooms of the hospital.

A banquet honoring Doctor and Mrs. Conn will be held that evening in the Vandenberg Room of the University of Michigan League.

Reservations for the banquet may be made by sending a check for $10 per person, made payable to the Jerome W. Conn Symposium, to S. S. Fajans, MD, C7204, University of Michigan Hospital, Ann Arbor, Michigan 48104, by October 10.

Further details of the Symposium may be obtained from the Division of Endocrinology and Metabolism, C7204, University of Michigan Hospital.

Physicians, Others Form New Perinatal Group

Membership now is open in the new Perinatal Association of Michigan, formed by a group of physicians and other professionals, with consumer representation, to promote optimal care for pregnant women and infants.

Bruce A. Work, Jr., MD, of Ann Arbor, is acting chairman of the board of trustees, which includes dieticians, educators, social workers, consumers and physicians. Plans call for state-wide and regional meetings, a continuing educational program and a quarterly newsletter.

Membership information is available from Mrs. Linda Stears, RN, Neonatology Service, Bronson Methodist Hospital, Kalamazoo, Mich. 49006.

Cervical Cancer Target of Program

The Michigan Cancer Foundation has been awarded a million-dollar sub-contract from the Michigan Department of Public Health to conduct a three-year cervical cancer screening program in "high risk" population areas of Wayne, Oakland and Macomb counties. The goal is to provide 25,000 women with free Pap tests during the first year. Funds for the sub-contract were issued through the National Cancer Institute, an agency of the U.S. Department of Health, Education and Welfare.

Million-dollar Grant for New Hospital

The Kresge Foundation has awarded William Beaumont Hospital, Royal Oak, a grant for one million dollars toward construction costs for a 200-bed associated hospital to be built in Troy. Ground for the Troy hospital was broken in March and completion is expected in 1976.

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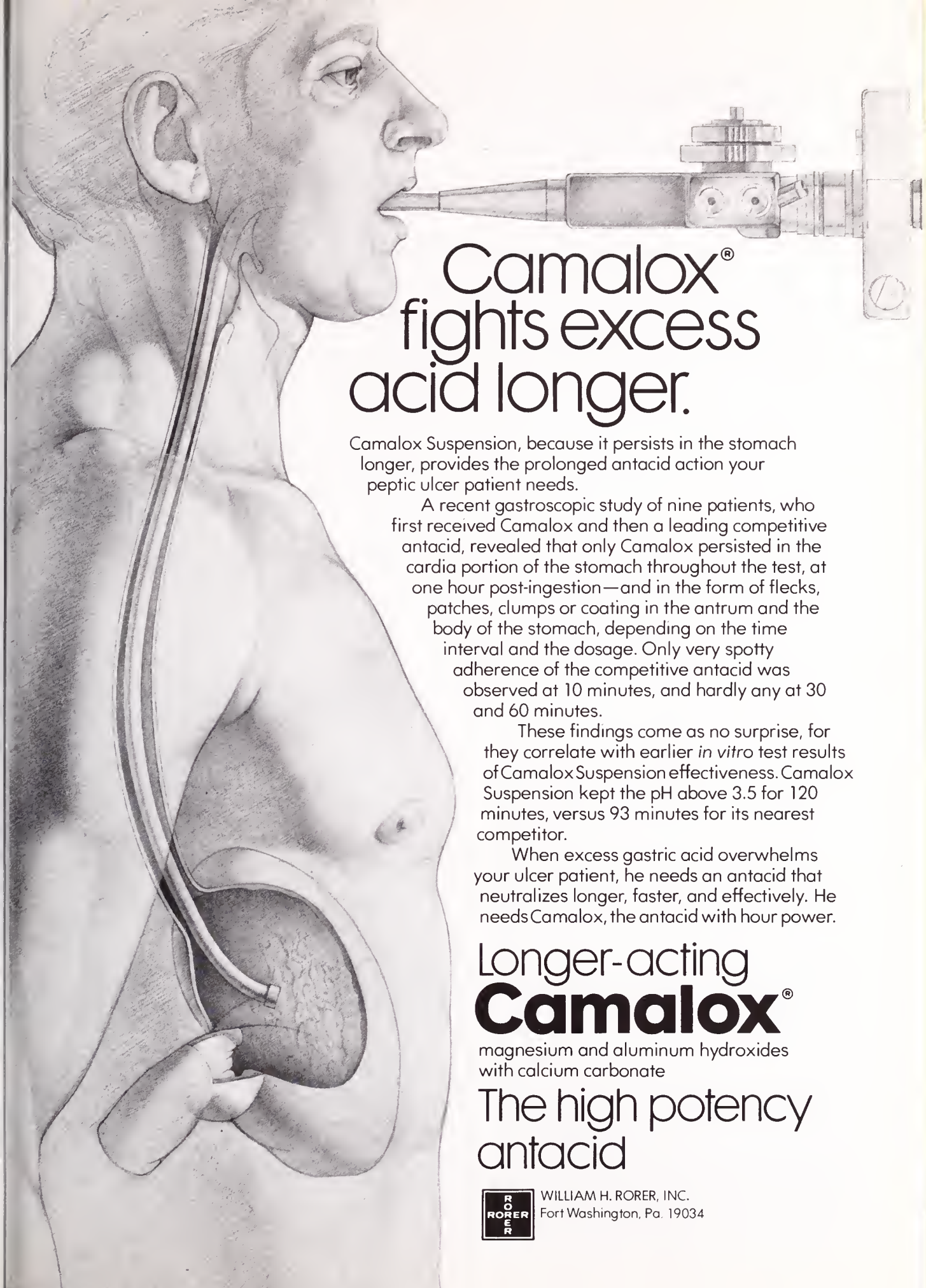

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MEETINGS

Aug. 20 & 21—PSRO Seminar sponsored by the Commission on Professional and Hospital Activities at its Ann Arbor headquarters, contact: CPHA, 1968 Green Rd., Ann Arbor 48105.

Sept. 5—PAS and MAP Institute sponsored by the Commission on Professional and Hospital Activities, at Ann Arbor, contact: CHPA, 1968 Green Rd., Ann Arbor, 48105.

Sept. 9-11—Continuing education course on "Early Care of the Injured Athlete" produced by the Committee on Sports Medicine, American Academy of Orthopaedic Surgeons in cooperation with the University of Michigan at U-M, Ann Arbor, contact: American Academy of Orthopaedic Surgeons, 430 N. Michigan Ave., Chicago, Ill. 60611.

Sept. 11-13—Postgraduate course on selected topics in endocrinology and metabolism sponsored by the American College of Physicians at the Indianapolis Hilton Hotel contact: ACP, 4200 Pine St., Philadelphia 19104.

Sept. 16-20—Family Practice Review sponsored by the WSU School of Medicine and the Michigan Academy of Family Physicians, Scott Hall, WSU, contact: Dwight M. Schroeder, MD, Department of Family Medicine, WSU School of Medicine, Detroit 48201.

Sept. 20—Fourth Annual Michigan Cardiovascular Research Forum, sponsored by the Michigan Heart Association at Harper-Webber Hospital, Detroit, contact: Beverly Mercil, MHA, PO Box LV 160, Southfield 48076.

Sept. 20 & 21—Fifth Annual Symposium on "Oral and Perioral Ulcerations: Cause and Control, Emphasis on Herpes Simplex Virus," sponsored by the University of Michigan School of Dentistry and Dental Research Institute, at Kellogg Auditorium, Ann Arbor, contact: Charles B. Cartwright, DDS, U-M School of Dentistry, Ann Arbor, 48104.

Sept. 21 & 22—Postgraduate seminar, "Upper Midwest Review of Gastroenterology," sponsored by the Medical College of Wisconsin's Department of Surgery, Pfister Hotel, Milwaukee, contact: Anne T. Finnegan, Medical College of Wisconsin, Milwaukee 53233.

Sept. 24-26—Postgraduate course on blood coagulation techniques, U-M Medical Center.*

Sept. 25—MSMS Council, MSMS Headquarters, contact: Warren F. Tryloff.

Sept. 27—Annual Meeting of the Michigan Society of Internal Medicine at Hidden Valley, Gaylord, contact: MSIM, PO Box 740, East Lansing 48823.

Sept. 27-29—Michigan Regional Meeting, American College of Physicians, Otsego Ski Club, Gaylord, contact: Beverly C. Payne, MD, 425 W. Washington St., Ann Arbor 48108.

Oct. 1—Annual surgical symposium, "Surgical Disease of the Pediatric Gastrointestinal Tract," sponsored by the Department of Surgery, Children's Hospital of Michigan, and Wayne State University School of Medicine Department of Surgery, at the hospital, contact: Department of Community Relations, Children's Hospital of Michigan, 3901 Beaubien Blvd., Detroit, Mich. 48201.

Oct. 2—Postgraduate course on "Illness in Children" for social workers, U-M Medical Center, Ann Arbor.*

Oct. 4—Mid-year Meeting, Michigan Hospital Association, Park Place Motor Inn, Traverse City, contact: MHA office, 2213 E. Grand River Ave., Lansing, Mich. 48912.

Oct. 8-10—Postgraduate course in cardiology for internists, U-M Medical Center, Ann Arbor.*

Oct. 9 & 10—1974 Annual MSMS Scientific Meeting, Sheraton-Cadillac Hotel, Detroit, contact: Helen Schulte, MSMS Headquarters.

Oct. 10—Annual MSMS Leadership Conference and MSMS Awards Luncheon, Sheraton-Cadillac Hotel, Detroit, (in conjunction with the Annual Scientific Meeting), contact: Herbert A. Auer, MSMS Headquarters.

Oct. 11 & 12—Annual reunion of the University of Michigan Medical Center Alumni Society, Ann Arbor.*

Oct. 19—Seminar on "Pediatric Pathology" sponsored by the Michigan Society of Pathologists at the University of Michigan, Ann Arbor, contact: Robert Hendrix, MD, U-M Medical Center.

Oct. 21-25—American College of Physicians postgraduate course on new developments in diagnosis and treatment of disease with radionuclides, co-sponsored by U-M Medical Center, at Towsley Center, Ann Arbor, contact: ACP, 4200 Pine St., Philadelphia 19104.

Oct. 31-Nov. 2—Course on "Implant Surgery for Joints and Tendons in the Hand," sponsored by the American Society for Surgery of the Hand, at Blodgett Memorial Hospital, Grand Rapids, contact: Alfred B. Swanson, MD, 313 Blodgett Medical Bldg., Grand Rapids, Mich. 49506.

Nov. 6—MSMS Council, MSMS Headquarters, contact: Warren F. Tryloff.

Nov. 7 & 8—Cardiovascular symposium on "Diagnosis and Treatment of Congenital Heart Disease," sponsored by Children's Hospital of Michigan and Wayne State University School of Medicine, at the hospital, contact: Eduardo Arciniegas, MD, or Edward Green, MD, WSU School of Medicine.

Nov. 8 & 9—Postgraduate course on advanced burn care, U-M Medical Center, Ann Arbor.*

Nov. 13—Postgraduate course on "Medicine and Law: Trends and Protections," U-M Medical Center, Ann Arbor.*

Nov. 15—Workshop on "New Health Practitioners—Partners in Patient Care," sponsored by the Institute of Medicine of Chicago, Sheraton-Blackstone Hotel, Chicago, contact: Institute of Medicine, 332 S. Michigan Ave., Chicago, Ill. 60605.

Nov. 15 & 16—Postgraduate anesthesiology conference, U-M Medical Center, Ann Arbor.

Dec. 4—Postgraduate course in cardiology for family physicians, U-M Medical Center, Ann Arbor.*

Dec. 5—PAS and MAP Institute sponsored by the Commission on Professional and Hospital Activities, at Ann Arbor, contact: CHPA, 1968 Green Rd., Ann Arbor, 48105.

Dec. 6—Postgraduate course in basic burn care, U-M Medical Center, Ann Arbor.*

Dec. 11—MSMS Council, MSMS Headquarters, contact: Warren F. Tryloff.

Jan. 10 & 11, 1975—Respiratory therapy conference, U-M Medical Center, Ann Arbor.*

Jan. 20-24, 1975—Family practice review, U-M Medical Center, Ann Arbor.*

Feb. 3-7, 1975—American College of Physicians postgraduate course on current concepts in oncology, co-sponsored by U-M Medical Center, at Towsley Center, Ann Arbor, contact: ACP, 4200 Pine St., Philadelphia 19104.

Feb. 18-20, 1975—Postgraduate course in EKG diagnosis, U-M Medical Center, Ann Arbor.*

Feb. 25-28, 1975—Postgraduate course in emergency medicine, U-M Medical Center, Ann Arbor.*

March 5 & 6, 1975—Postgraduate course in advances in pediatrics, U-M Medical Center, Ann Arbor.*

March 7, 1975—Postgraduate course in basic burn care, U-M Medical Center, Ann Arbor.*

March 10 & 11, 1975—Postgraduate course on "Surgical Complications: Prevention and Management," U-M Medical Center, Ann Arbor.*

March 18-20, 1975—Postgraduate course in morphology, U-M Medical Center, Ann Arbor.*

March 31-April 2, 1975—OB-GYN conference, U-M Medical Center, Ann Arbor.*

April 16, 1975—Postgraduate course on orthopedics in family practice, U-M Medical Center, Ann Arbor.*

April 17 & 18, 1975—Course on "Medical Technology/Hematology," U-M Medical Center, Ann Arbor.*

April 21-25, 1975—American College of Physicians postgraduate course on recent progress in clinical endocrinology, co-sponsored by U-M Medical Center, at Towsley Center, Ann Arbor, contact: ACP, 4200 Pine St., Philadelphia 19104.

April 24 & 25, 1975—International conference on andrology, "The Human Semen and Fertility Regulation in the Male," at Wayne State University School of Medicine, contact: E.S.E. Hafez, Ph D, WSU School of Medicine, 550 E. Canfield, Detroit, 48201.

May 1 & 2, 1975—Ophthalmology conference, U-M Medical Center, Ann Arbor.*

May 13 & 14, 1975—Postgraduate course in therapeutics, U-M Medical Center, Ann Arbor.*

June 3-6, 1975—Postgraduate course on "Advances in Internal Medicine," U-M Medical Center, Ann Arbor.*

June 11 & 12, 1975—Postgraduate course on sexual problems in family practice, U-M Medical Center, Ann Arbor.*

June 23-27, 1975—Northern Michigan summer postgraduate education course for physicians, sponsored by the U-M Medical Center, at Shanty Creek Lodge, Bellaire.*

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*Contact Robert K. Richards, Towsley Center, University of Michigan, Ann Arbor 48104.

Michigan Medicine each month lists upcoming meetings in Michigan or of special interest to Michigan physicians if out of state. Please submit notices for publication at least two months prior to meeting dates.

Welcome

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

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Gabriel G. Almeida, MD, Gratiot Comm. Hosp., Alma 48801
John P. Anders, MD, 1030 Sixth St., Traverse City 49684
Mohammed R. Ansari, MD, 2799 W. Grand Blvd., Detroit 48202
Kumbla P. Bhakta, MD, 25210 Grand River, Detroit 48240
Bartol Biocic, MD, 461 W. Huron St., Pontiac 48053
Henry R. Boer, MD, Hurley Hosp., Flint 48502
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Jaime Navarro Ching, MD, 22146 Ford Rd., Dearborn 48127
Ralph A. Clark, MD, 106 E. State St., Scottville 49454
Carolyn A. Creighton, MD, 1200 Byron Rd., Howell 48843
Harold Dumas, MD, G-5067 W. Bristol Rd., Flint 48507
Godofredo G. Gannod, MD, 7845 Middlebelt Rd., Romulus 48174
Oliver D. Grin, Jr., MD, 833 Lake Dr., SE, Grand Rapids 49506
Masud Ali Khan, MD, Saline Community Hosp., Saline 48176
Fred S. Lamb, MD, 502 Webster St., Traverse City 49684
Kheng Bee Lim, MD, 2442 E. Maple Ave., Flint 48507
Anand M. Manohar, MD, 24210 Grand River, Detroit 48240
H. K. Mariyappa, MD, 858 Pipestone Rd., Benton Harbor 49022
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Pablo B. Martinez, MD, 1605 Fred Moore Hwy., St. Clair 48079
Michael McAuliffe, MD, Mill St. Prof. Bldg., Adrian 49221
Constantine T. Nicholas, MD, 409 Bronson Med. Ctr., Kalamazoo 49006
Edward R. Powsner, MD, 485 Riverview Dr., Ann Arbor 48104
Saul M. Rubenstein, MD, 21412 Buttercrest, Southfield 48075
Leonard Sahn, MD, Univ. Hosp., Dept. of Neurology, Ann Arbor 48104
Delores Sion, MD, 604 E. Pottawatami St., Tecumseh 49286
Geoffrey A. Trivax, MD, 23401 Beverly, Oak Park 48237
Fong H. Tse, MD, 1852 W. Grand River Blvd., Detroit 48208
George A. Tumaneng, MD, 5210 Lapeer Rd., Flint 48503
Marinus Van Ooyen, MD, Bixby Hospital, Adrian 49221
Felipe G. Videla, MD, P. O. Box 7179, Flint 48507
David M. Woodliff, MD, 1005 W. Green St., Hastings 49058

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the past were used fairly frequently for relatively minor hemorrhage. Now this is considered poor practice because regardless of how carefully blood is typed, crossmatched and otherwise tested, fatal transfusion reactions may occur or hepatitis-B develop. Chloramphenicol was used liberally until it was identified with deaths from aplastic anemia. Methotrexate, used primarily for the treatment of leukemia, where it obviously is justified, can produce fatal bone marrow and liver damage. A few years ago it was used to treat the benign, but unsightly, psoriasis. A drug induced death has essentially stopped this form of therapy.

If the tubercle bacillus, or virus of a potentially fatal form of encephalitis, packed tremendous energy for fueling electrical plants, would it be rational to culture these organisms by the ton and ship them around this nation and the world for such a purpose? Hardly, and yet they are not nearly as deadly as plutomium-239. Simple, adequate heating destroys them forever. Multiple drugs are available for the treatment of tuberculosis. Vaccines can be used to prevent some forms of encephalitis. However, one pound of plutonium-239, efficiently administered, could cause billions of lung cancers, for which there is no effective treatment. It has a half-life of 24,000 years. To expect 100 per cent containment of this material is highly unrealistic, yet essential.

Waste Disposal Problems

One thousand nuclear power stations are planned for the United States by the year 2000. Yet there is no satisfactory method for the disposal of their highly toxic wastes, only perpetual guardianship for tens of thousands of years. Is it rational to proceed with the one source of electrical power, nuclear fission, which, of all sources, is the most likely to compromise the health, even the very existence of mankind?

Those in positions of influence on this matter, including the medical profession, bear a grave responsibility. The more we learn of nuclear power, the more reasons we have for abandoning it and turning to alternate sources. To me, it now appears morally wrong and financially unwise to continue our present course. A moratorium on nuclear power plant construction coupled with intense research and development programs for other energy sources and for electrical energy conservation may well be indicated.

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In Memoriam

Eugene J. Alexander, MD
Port St. Lucie, Fla.

Eugene J. Alexander, MD, 64, of Port St. Lucie, Fla., a retired member of MSMS and a former staff member at Henry Ford Hospital, Detroit, died May 6. A psychiatrist, he was a graduate of the Indiana University School of Medicine.

Jack E. Coakes, MD
Marshall

Jack E. Coakes, MD, 49, of Marshall, died June 14 in the Battle Creek Veterans Administration Hospital. Doctor Coakes, a graduate of the University of Michigan Medical School, practiced in Marshall from 1954 until 1967 when ill health forced his retirement.

Raymond G. Colyer, MD
Birmingham

Raymond G. Colyer, MD, 75, of Birmingham, a specialist in industrial medicine, died June 23. Doctor Colyer retired in 1966 as medical director for Fisher Body Division of General Motors Corp. He was a graduate of the University of Illinois College of Medicine and saw military service during World War I.

Forrest W. Larson, MD
Houghton

Forrest W. Larson, MD, 51, of Houghton, died June 30. A native of Ironwood, Doctor Larson was graduated from the University of Michigan Medical School. He was a former chief of staff at St. Joseph's Hospital, Hancock.

Frank H. Purcell, MD
Detroit

Frank H. Purcell, MD, 80, Detroit orthopedic surgeon and former physician for the Detroit Lions, died June 30 in Bon Secours Hospital, Grosse Pointe. He had been attending orthopedic surgeon at Grace Hospital and a staff member at several other Detroit area hospitals.

Raymond J. Screen, MD
Detroit

Raymond J. Screen, MD, 58, of Detroit, died April 27. Doctor Screen, a radiologist, was on the staffs of Trumbull General and Herman Kiefer hospitals. He received his medical education at Tulane University. He was a World War II veteran.

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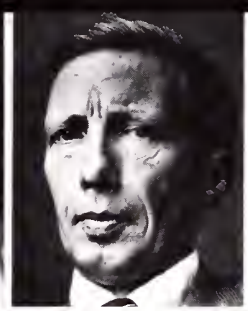

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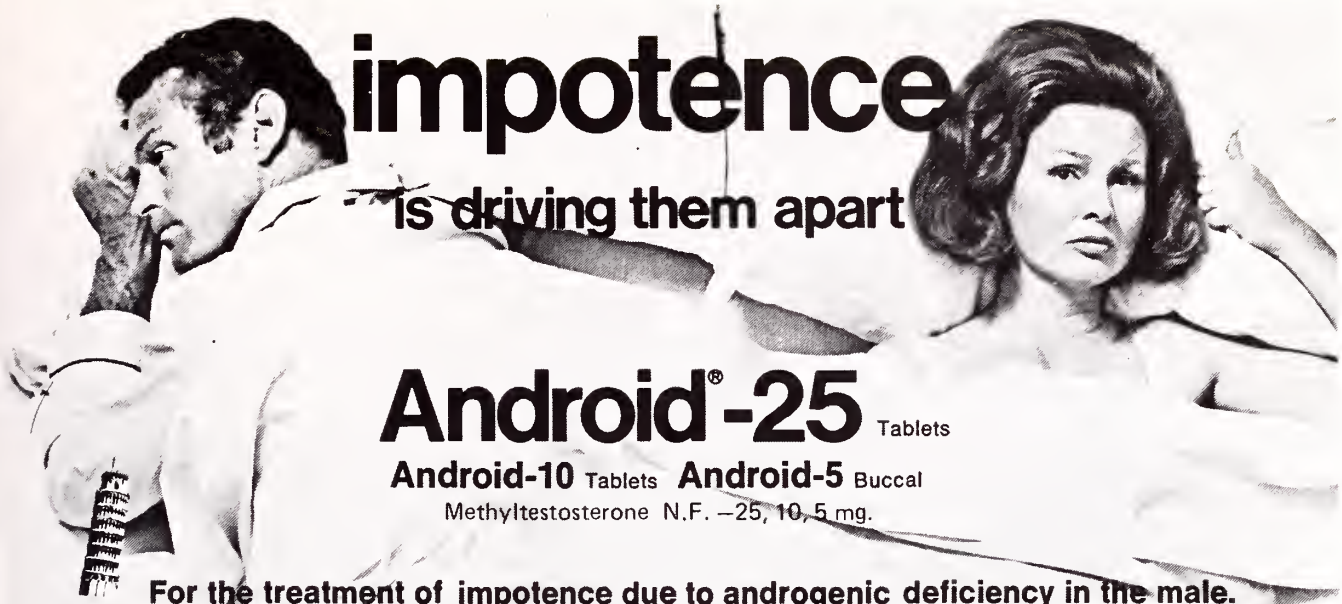

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Beating the Deadline

Dr. Hurth

Dr. Giddings

Dr. Bennett

Dr. Hubbard

Dr. Bond

By Herbert A. Auer, Executive Editor

A feature story in the *Lansing State Journal* reports that some former patients still telephone **Mathias Hurth, MD,** at his Lansing home to ask for medical advice and an appointment. But Doctor Hurth has made his retirement stick after 56 years of ministering to the sick. Mayor Gerald Graves proclaimed June 8 Doctor Mathias S. Hurth Day in honor of the physician.

A new doctor at St. Joseph, **William K. Rock,** came to Berrien County from Switzerland, where he was in clinical research.

When the Battle Creek Sanatarium closed recently, **A.M. Giddings, MD,** the house doctor, closed out 64 years of practice. He practiced first in Augusta and then many years in Battle Creek. **John Harvey Kellogg, MD,** brought attention to the sanatarium where he served as director, beginning in 1876.

The Detroit Chapter of Squawz, a national organization of prominent Black women, recently selected the "Ten Best Dressed Black Men in Detroit" and honored **Germany Bennett, MD,** with a place on the list.

Former dean of the U-M Medical School, **William N. Hubbard, Jr., MD,** has been nominated by President Nixon to the board of the National Science Foundation. Doctor Hubbard now is president of the Upjohn Company, Kalamazoo.

Daniel P. Hornbogen, MD, of Marquette, has retired from the board of directors of the Union National Bank and Trust Company after 27 years. He has practiced in Marquette for 50 years.

William W. Bond, MD, of Monroe, was honored recently at the University of Tennessee School of Medicine, where he was graduated 50 years ago. He has served the people of Monroe since 1927.

John W. MacKenzie, MD, Swartz Creek, has completed his year as president of the Human Services Planning Council for Genesee County. His efforts date back to 1961 when he was appointed the representative of the Genesee County Medical Society to the board of directors of the local Council of Social Agencies.

This page will appear each month with news items "on the human side" gathered from correspondence, meetings, conversations and tips we hope you will send in from time to time.

Digest of Proceedings

MSMS House of Delegates
1974 Annual Session
May 5-7, Boyne Falls

1974 House of Delegates Proceedings
109th Annual Session
Michigan State Medical Society

How to Use This Digest

For your convenient use of the *Digest of Proceedings,* please note the following arrangement of contents:

Each report is followed immediately by the action of the reference committee on that report and then by the House action on the report of the reference committee. Resolutions are printed as they were finally approved or disapproved by the House.

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CALL TO ORDER AND SPECIAL REPORTS

1. Call to Order

The 109th Annual Session of the House of Delegates of the Michigan State Medical Society, held at Boyne Mountain Lodge, Boyne Falls, Michigan, convened at 2:35 p.m., Vernon V. Bass, MD, Speaker, and James D. Fryfogle, MD, Vice Speaker, presiding.

2. Invocation

The Speaker called upon A. Stewart Kerr, the Parliamentarian, to give the invocation.

3. Report of Committee on Credentials

Chairman Charles E. Conaway, MD, reported a quorum seated, the majority of whom were not from any one county.

4. Report of the Committee on Rules and Order of Business

Chairman Charles L. Oppy, MD, reported that the Committee on Rules and Order of Business held its meeting in East Lansing on March 13, 1974. Speaker Vernon V. Bass, MD, attended the meeting as a guest of the Committee.

Order of Business for 1974 Annual Session. The Committee amended and approved the Order of Business for printing in the Delegates Handbook.

Action on Late Resolutions. As authorized by the House, this Committee will rule individually on any late resolutions according to their urgency and determine which are urgent and should be received after the deadline for presentation.

Site for 1974 Annual Session. The Committee considered a request from the Wayne County Medical Society that the site for the 1974 House of Delegates be changed from Boyne Mountain to a location in the Detroit area because of the gasoline shortage. The Committee studied this matter and concluded that it could not change the location of the Annual Session because the Boyne Mountain site was decided upon by the House of Delegates at the 1973 Annual Session and committments have already been made to Boyne Mountain for use of their facilities.

Request from President Masters. The Committee considered a request from Doctor Masters that Carl Smith, Jr., Esq., President of the State Bar of Michigan, be invited to address the delegates at the opening session on Sunday afternoon, May 5, rather than be listed as a discussion leader for one of the forums. Doctor Masters explained that he had been invited to address the State Bar Representative Assembly on March 2 and that Mr. Smith should be accorded a similar courtesy. The Committee agreed and the address by Mr. Smith is listed as No. 9 on the Order of Business. The Committee, however, considers this an exception to the general rule that outside speakers are not invited to address the House of Delegates during any of its regular sessions.

Special Notes. The Committee wishes to call special attention to the Forums for Delegates at 3:00 and 4:00 p.m. on Monday, May 6, and the 7:30 p.m. Seminar. The subject for the Seminar will be "Improving Communications with Members" and the subjects for the Forums will be "Funding of Graduate Medical Education including a Discussion of the SHOTS Program" and "Continuing Education for Physicians; Voluntary — Mandatory."

Election of Officers. The Committee reviewed the action of the 1973 House of Delegates re special election procedures that would implement the changeover from a Fall Annual Session to a Spring Annual Session. The Committee is of the opinion that the intent of the House was to elect AMA delegates and alternates as well as councilors and officers at the Spring 1975 Annual Session.

THE HOUSE adopted the Report of the Committee on Rules and Order of Business.

5. Speakers Remarks — Vernon V. Bass, MD

The Speaker outlined the plans and procedures of the House.

(The following report of the Speaker was presented to the delegates in printed form.)

Speaker's Report, 1973 Annual Session

This is a brief review of the implementation of resolutions adopted by the 1973 Annual Session of the House of Delegates. (For complete text of resolutions with House Action, refer to the Digest of Proceedings, Michigan Medicine, Vol. 72, No. 36)

No action was taken on Resolutions 73A-10, 73A-11, 73A-22, 73A-29 and 73A-30. Resolutions 73A-1, 73A-5, and 73A-6 were disapproved.

Sub.

73A- 2— Position on PSRO. (Substitute Resolution in lieu of 73A-2, 73A-17, 73A-18, and 73A-19, Adopted as Amended.) This resolution called for (1) the repeal of PSRO through all methods available, (2) continuing monitoring of PSRO developments, (3) amendments to the PSRO law if it is not repealed, (4) development of alternative plans for peer review, (5) sending copies of the resolution to the AMA House of Delegates, to each state medical society, to every MSMS member, and the Michigan congressional delegation, and (6) any implementation of PSRO by a decision of the House of Delegates.

The Council assigned efforts to repeal the law

to the Committee on Governmental Medical Care Programs. Monitoring PSRO and development of alternative peer review systems was assigned to the Ad Hoc Committee on Peer Review Systems.

Immediately following the House of Delegates, MSMS apprised every Michigan member of Congress of the MSMS action, and urged each congressman to act in behalf of repeal. MSMS received 13 responses, only two of which gave any indication or desire to seek immediate repeal.

The Michigan delegation to AMA submitted a resolution pursuant to the MSMS action calling for repeal of PSRO. The Michigan delegation was instrumental in drafting the final AMA language, declaring a firm commitment to peer review under professional direction, urging local medical societies to develop their own "unassailable" peer review procedures, urging modification of PSRO legislation and stating, "The best interests of the American people, our patients, would be served by the repeal of the present PSRO legislation."

The MSMS Council adopted the AMA language as Michigan's position on PSRO and Michigan congressmen were thus informed.

The Government Medical Care Programs Committee, subsequent to the AMA action, thoroughly reviewed all repeal efforts to date, both by MSMS and AMA. It then recommended to The Council that repeal *immediately* was unlikely, and that the best chance lay in MSMS coordinating with AMA in all its repeal efforts. The Council adopted the committee's recommendation, and AMA was thus informed.

A committee of MSMS leadership met in Washington with staff from 17 Michigan congressmen and senators to report on PSRO activity in Michigan and to urge repeal. The rationale for the repeal efforts was thoroughly aired.

In an AMA survey by state societies of congressional climate for PSRO repeal, MSMS reported only two of 19 congressmen supported repeal now.

PRSO repeal rationale was explained once more to Michigan congressmen through participants in the MDPAC Congressional reception in Washington.

The Ad Hoc Committee on Peer Review Systems consulted with county medical societies re PSRO area designations. Final PSRO area designations were published in the Federal Register on Monday, March 18, 1974. Michigan now has ten areas which are identical to the MSMS recommendations reflecting desires of component medical societies.

The Committee is now studying several review systems, including Ohio's Medical Advances Institute, that are in various stages of development. Although the Committee is unable to recommend a viable alternative to PSRO for adoption by MSMS at this time, a committee member, Leland Holly, II, MD, developed a "Guideline for Regional Peer Review," which has been sent to members of the House of Delegates for information.

The MSMS Council authorized appropriate MSMS Committees and task forces to assist county medical societies in establishing peer review mechanisms and to seek HEW designation of MSMS as a Statewide Professional Standards Review Organization Support Center so that guidelines for the establishment and operation of PSRO can be communicated and explained to county medical societies upon request. Work is proceeding so that MSMS proposal will be submitted prior to the April 30th deadline. In the meantime the Wayne County Medical Society Council has authorized its Committee on PSRO Programs to make application for a planning grant and the Genesee Medical Corporation is proceeding to make application to qualify as a conditionally designated PSRO to serve Genesee, Lapeer and Shiawassee counties.

73A- 3— Community Non-Sectarian Hospital Abortion Service Privileges. (Adopted as Amended.) This resolution asked that MSMS use its influence to achieve a goal that would permit physicians in only community non-sectarian hospitals to have the authority to offer abortion services in that hospital, constrained only by state guidelines. The state legislature, which had a number of different abortion bills to study, passed a bill (signed by the Governor) which permits doctors and personnel to follow their conscience in deciding whether to do abortions.

73A- 4— Repeal of State Sales Tax and Prescription Drugs. (Adopted as Amended) MSMS informed all legislators of its attitude toward sales tax on drugs and such devices that are taxed. The issue will probably appear in constitutional amendment form on which all registered voters of Michigan will vote.

73A- 7— Abandonment of Physicians' Profiles. (Substitute Resolution, in lieu of 73A-7 and 73A-12, Adopted) This resolution asked that MSMS reaffirm its support of the concept of usual, customary and reasonable fees without regionalization. This feeling was relayed to Michigan Blue Shield and the Michigan Department of Social Services. Michigan Blue Shield has responded via a letter detailing their reasons for their policies. The resolution also asked that MSMS members be informed on how to obtain acceptable fees. Regulations under the Federal Economic Stabilization Program have been detailed in Michigan Medicine, Medigram and the socio-economic Research Bulletin. There have also been several presentations made at county medical society meetings.

73A- 8— *Regulation of Motorcycle Use. (Adopted as Amended)* This resolution voiced MSMS concern about the increasing number of injuries and deaths from motorcycle accidents and authorized MSMS to encourage safety educational programs. The safety program will be carried out by the MSMS Committee on Public Relations and MSMS Department of Communications in the spring with a concerted effort during May.

73A- 9— *Lifetime Medical Financing System. (Referred without action to the Committee on Professional Insurance Plans for further study)* The Bureau of Economic Information met in consultation with the Committee on Professional Insurance Plans to discuss the necessity of surveying the MSMS members as to their interests in a high deductible coinsurance health care plan. The Committee decided that it would not be necessary to conduct a survey because member interest in a possible plan was demonstrated by the reply given to the offerings of the now functioning Blue Shield Econo-Plan.

73A-12— *Equal Fees for Equal Service. (See Resolution 73A-7).*

73A-13—*Shortage of Physicians. (Substitute Resolution, in lieu of 73A-13 and 73A-14, Adopted as Amended)* This resolution voiced MSMS concerns for more primary care physicians in Michigan. The specific actions suggested have been completed, such as, (1) letters have been sent to the deans of the three medical schools, (2) letters were sent to the directors of training at the six hospitals with family practice residency programs, (3) letters were sent to the Boards of Trustees of all Michigan hospitals, and (4) MSMS news releases and speeches sought to encourage more physicians to train as primary care specialists. MSMS also encouraged Michigan doctors to serve as preceptors for the medical schools' primary care preceptorship projects and also for the SAMA-MECO summer project conducted by MSMS.

73A-14— *Need for Primary Care Physicians. (See Resultion 73A-13)*

73A-15— *Involuntary Sterilization. (Substitute Resolution, in lieu of 73A-15, Adopted)* The MSMS delegation to the AMA carried this matter to the Judicial Commission of the AMA where similar action by several other states now pends. No definite action has been taken by AMA.

The Maternal Health Committee appointed a study committee at its January meeting, which will report soon.

73A-16— *Encourage Generic Prescribing (Adopted as Amended)* MSMS has opposed proposed legislation to repeal the prohibition of substitution on generic drugs without adequate quality control by physicians.

73A-17— *Opposition to PSRO. (See Resolution 73A-2)*

73A-18— *Opposition to PSRO. (See Resolution 73A-2)*

73A-19— *Opposition to PSRO. (See Resolution 73A-2)*

73A-20— *Discriminatory and Unfair Controls on Health Care Providers. (Adopted as Amended)* AMA has been very active against discrimination by the Cost of Living Council and has filed suit in Federal Court challenging the ceiling on physician fees. MSMS conducted a vigorous campaign to inform Michigan congressmen of its feelings on this matter. Responses from congressmen indicate an awareness of physician problems regarding this cost of living council.

73A-21— *Rotating Internship. (Adopted as Amended)* This resolution was taken to the AMA where three other resolutions expressing concern about graduate medical education were referred to The AMA Council on Medical Education for a report at the 1974 AMA Annual Meeting.

73A-22— *Funding of Graduate Medical Education. (No Action on this resolution, but approved a recommendation from the Reference Committee)* This resolution called on The Council to appoint an Ad Hoc Committee to Study the Funding of Graduate Medical Education and to report to the 1974 Annual Session of the House. The Committee's charge was to study the Indiana Program and other programs relating to the financing, training evaluation and expanded manpower factors of graduate medical education and to explore potential sources of funding such programs in Michigan. The Ad Hoc Committee reported its findings to The Council. The Council has studied this proposal and its report to the House will be included in the Council Chairman's remarks.

73A-23— *Compliment Governor Milliken re Environment. (Substitute Resolution, in lieu of 73A-23, Adopted)* The Governor was informed by letter of the House action on this resolution.

73A-24— *Financing Medical Education. (Referred, without action, to appropriate Committee for study and recommendation at next House of Delegates meeting.)* Senator Robert Vander Laan has submitted a bill to establish a revolving medical loan act (SB 952). The bill was reported favorably by the Senate Education Committee and is now in Senate Appropriations Committee where action is pending. The Committee on Legal Affairs and The Council had input in the development of SB 952 and support the concepts embodied in the bill.

73A-25— *Support of Hospital Medical Staff. (Adopted)* Adopted an MSMS policy that hospital medical staff bylaws should be made only in consultation with and approval of the medical staff. MSMS sent a letter explaining this position to the Boards of Directors of all Michigan hospitals.

73A-26— *Combatting Hypertension. (Adopted)* This resolution was referred to the Committee on Public and Environmental Health which en-

dorsed the action of the House of Delegates and presently is working toward the development of hypertension detection and treatment programs on the local and state level.

73A-27— Supporting Immunization Month. (Adopted as Amended) This resolution authorized MSMS participation in the national "Immunization Month" in October 1973. The MSMS began its planning during the summer of 1973 for such a project. MSMS issued news releases, distributed radio and TV spots, held news conferences, printed posters for doctors' offices, etc. in an extensive effort to increase the level of protection. MSMS worked closely with the Wayne County Medical Society in the Detroit effort. MSMS received letters of appreciation and commendation from the State Department of Public Health.

73A-28— MD Placement in Health Council. (Adopted as Amended) This resolution called for continued support of the Michigan Health Council by improved liaison and public relation efforts to explain the functions and purposes of the Michigan Health Council. A formal liaison committee has been appointed and the directives of the resolution are being carried out.

73A-31— A Single Plan for Medical Care Insurance. (Adopted as Amended)

73A-32— Governmental Role in Financing Medical Indigents. (Adopted) These resolutions involved an in-depth study and development of medically accepted guidelines for a comprehensive health program. Suggested inclusions in a single plan for medical care insurance were provided in the resolutions.

It was the opinion of the Committee on Medical Care Delivery that MSMS does not have the necessary funding and manpower to carry out the in-depth study proposed. Several of these considerations are included in bills now before Congress concerning national health insurance programs.

73A-33— Medical Care Delivery to the Needy. (Adopted) This resolution concerned medical care delivery to the needy by development of a system utilizing all physicians in any given area and to provide physicians for needy areas. The development of an educational program directed to physicians before and after graduation stressing the importance and urgency of accepting civic responsibility was a part of the resolved.

The Committee concluded that these resolutions should be held for further consideration as other anticipated ideas on a national health delivery system are received from AMA.

73A-34— Opening Hearings for Members. (Substitute Resolution, in lieu of 73A-34, Adopted) Encouraged component societies to hold "open meetings" for members on pertinent topics. A recommendation that components hold such meetings was sent to the president, president-elect, secretary and executive of each component. The general idea also was promoted to delegates and members-at-large.

73A-35— Constitutional Amendment on Abortion. (Adopted) The Michigan House of Delegates resolution was transmitted verbatim to the AMA House of Delegates. The AMA reaffirmed its existing policy but took no action on the MSMS resolution.

6. President's Address — Brooker L. Masters, MD (Doctor Masters' address is excerpted here, copies of the full text are available on request.)

Althouth I have been in office only seven months, I have already developed a greater respect for the leadership provided last year by John J. Coury. Each of our past presidents has made unique contributions to our medical society. Doctor Coury set a fast pace as he traveled to component meetings, as he represented MSMS at state health planning meetings, and as he met with the younger physicians in Michigan.

Let me report today to you on my efforts to fulfill three promises we made to you last fall. The three goals outlined to you then continue to motivate me today.

1. To visit component medical societies to report on MSMS efforts and to listen to comments.
2. To speak before non-medical groups to interpret the concerns of the medical profession.
3. To exert leadership in bringing together interested parties to seek solution to problems facing the medical profession.

Since my installation, I have accepted every invitation extended by a component society to appear as a speaker. Already, I have traveled 9,000 miles from Fremont to nearly every corner of the State.

Let me shift now to talk about some of the non-medical groups we have conferred with. This phase of the MSMS presidency has been very challenging and very satisfying.

One of the possible solutions to the medical professional liability situation, I felt, was our relationships with the State Bar of Michigan. The Liaison Committee between the two groups had not met for several years and some of its early recommendations to improve interprofessional relationships had never been adopted. So we invited some of the leaders of the State Bar of Michigan to see if we had any common problems that could be studied. The Bar president, Carl Smith, supported the idea and three joint meetings were held in November and December. It should be no surprise to learn that each side did have some relationship problems. There does exist a sincere desire to study the issues and move toward some solutions.

In January, the five top officers of MSMS and top leaders of the Bar — along with members of three task forces conferred at the headquarters of the State Bar. The three task forces — each with three attorneys and three physicians — are at work on: 1) Interprofessional Relations, 2) Availability of medical and hospital records, and 3) Professional liability. The recommendations of the task forces will go to the parent liaison committee, and then move on to the policy-making bodies of the two professions.

There are other groups we must communicate with more effectively. One group is the Michigan Pharmaceutical Association. The pharmacists will hold their annual business meeting in June and I will address them on June 16. Again, my approach will be — "Sure we have differences from time to time, but let's cooperate in those areas of common concern." The pharmacists want to know the views of physicians on such matters as PSRO, HMO, the Physician Assistant program, continuing professional education, etc. On a state level, MSMS should have a strong liaison committee of physicians and pharmacists to develop a list of mutual concerns and work diligently to reach some compromises and some workable solutions.

MSMS has a foundation of growing relationships between the Michigan Hospital Association and the Michigan State Medical Society. For seven years, MSMS has worked actively with the MHA to conduct a "Forum for Hospital Administrators, Medical Chiefs of Staff and Hospital Board Members." Your president will speak at the 1974 Forum.

Talking about the health care team, I am impressed with the calibre of the "American Association of Medical Assistants — State of Michigan." That is the full name of the statewide association to which many of our medical assistants belong. That organization now is accrediting colleges to teach courses to enable these people to be of real help to us, and they have an outstanding certification program. On April 27, we spoke to the Michigan medical assistants at their 25th Annual Convention in Detroit, and chose to explain to them some of the reasons for rising health care costs. These loyal office assistants can be of great value to physicians and the medical society if we seek out ways to use them more effectively.

Certainly there is no way to thank the State Woman's Auxiliary and its members for the support and assistance they provide. The Auxiliary members contribute much in our communities to promote health careers, to serve meals on wheels, to write to legislators, etc., etc. On April 24 in Lansing, I spoke at the State Auxiliary Legislative Workshop to tell the ladies about our special concerns about legislation, about chiropractic, about our needs to work together.

I have worked very close with our MSMS Department of Communications to issue pertinent news releases and to be available for telephone interviews with the media. Recently, I spent 2 hours with the editor of the Detroit Free Press and his chief editorial writer. A long interview of the national health insurance question has already appeared in the Free Press. Just the other day, we met for 3 hours with Beverly Eckman, who is writing medical news for the Detroit News in place of Jean Pearson who has retired.

The second part of my report today will be an appeal to each of you to accept a challenge to tell our MSMS story to the physicians *and* to the public. Here are four specific suggestions to each of you . . .

First, when you get back home on Wednesday, tell your associates and others about the actions of the House of Delegates.

Second, make sure that the actions of the House are discussed at your next component medical society meeting. An unofficial summary will be in the mail on Thursday to all members, but you can interpret the issues and answer questions. Those of you from the larger components could offer a panel presentation. The components with medical society bulletins could run by-line articles on several of the major issues.

Third, take the initiative to get yourself on the agenda for your next hospital staff meeting so you can report to those doctors about the issues facing medicine in Michigan. Now, I would add a *fourth* personal appeal to each delegate and alternate and to the members of the MSMS Council.

Please help tell our story to the public. I am convinced that one of the solutions to our problems is for more one-to-one communications. There is no substitute for a personal appearance by a doctor — you — before the lawyers, pharmacists, nurses, or hospital workers in your community. Or before the ministers, teachers and the social workers. Or before the League of Women Voters, the Jaycees, or the labor unions.

Let me close today by saying:

First, thank you again for selecting me to be your spokesman. Last fall at the House meeting, I pledged to work with you . . . for you. The first seven months have been demanding, but rewarding. I am looking forward to the coming 11 months of this extended term.

7. Report of the Michigan Delegation to the American Medical Association — Donald N. Sweeny, Jr., MD, Chairman

The following is an excerpt report of the 27th Clinical Convention of the House of Delegates of the American Medical Association which met in Anaheim, California, Nov. 30, 1973, to Dec. 5, 1973. All MSMS Delegates and Alternates were present and caucuses were held each day. Doctors Rice, Engelke, Meyers and Bass served on Reference Committees.

The Business of the Convention is divided into the following sections:

I. Insurance and Medical Service:

AMA activities concerning PSRO was the principal item discussed at the convention. It consumed 4½ hours of Reference Committee time and 2½ hours of House time. Your Michigan delegation, mandated by the House of Delegates in Detroit (Oct. 1973 Resolution 73A-2) spoke for repeal of PSRO at the Reference Committee on the floor of the House of Delegates; and distributed a copy of the Michigan Resolution 73A-2 (Hillsdale County — Repeal of PSRO Amendment) to each delegate. A compromise position combining a position paper of the Council on Medical Service and the Board of Trustees was adopted after much debate. We as a Delegation submit to this Council and to the MSMS House of Delegates that we have carried their message aggressively, properly, and decorously. Although this action stopped short of an immediate, all-out campaign to demand immediate repeal, the position adopted was more than middle of the road and certainly embraced the words and the actions of the Michigan Convention. The Amended Report EE (AMA C-73) was accompanied by a 20-page review of pertinent amendments.

II. Legislation:

Comprehensive Health Planning and Abortion were the principal matters in this category.

The Michigan Resolution (#17) re Abortion called on the AMA to oppose an amendment to the Constitution of the United States which would prohibit abortion. Existing policy expressing the view that abortion is a medical problem to be considered under the law by a patient and her physician was reaffirmed in lieu of Resolution #17.

III. Medical Education:

Many reports on specific Residency Programs were accepted. Of other reports the following are of more than passing interest:

a) Resolution #18 (Michigan)

This concerned itself with opposition to certain curricular changes in postgraduate training and recognized the paramount importance of rotation through clinical disciplines to produce a well-rounded physician. It was referred with a mass of other material of similar suggestion to the Council on Medical Education for its guidance.

b) Resolution #20 (Foreign Medical Graduates)

This requested the AMA to stimulate the State Department to re-evaluate its open door policy regarding immigration of foreign physicians and to encourage repatriation of physicians to the country of their origin. Since entrance of such graduates is now under scrutiny of the Council of Health Manpower, the CME, and the Coordinating Council on Medical Education along with the Commission on Foreign Medical Graduates and various Federal agencies, the resolution was not adopted.

IV. Hospital Relations:

1. Boards of Trustees:

   There were several reports and resolutions concerning the necessity of having practicing physicians on hospital boards. Job descriptions for Hospital Administrators were commended. The AMA concluded that: the title of the hospital administrator should be locally determined and that the hospital administrator should have *no* vote at either medical staff or Board level.

2. Recertification or Relicensure:

   The House directed three of its Councils to prepare a joint (CME, CHM, and CMS) report on methods for measurement of the continuing competence of physicians using performance evaluation and continuing education as indices rather than challenge examination, and recertification as a goal rather than relicensure.

3. Health Care of Migrant Workers (CMS-C):

   This is a comprehensive progess report which suggests that it is feasible for the Federal Government to provide a method of nationwide health insurance to migrants. There was high praise for the report. It should be distributed to the proper committee of MSMS as a working paper.

4. Quality Assurance Program (AHA):

   After considerable discussion, QAP was made the business of a liaison committee between AMA and AHA for discussion. It is hoped, but not predicted, that a vehicle will be produced by which misunderstandings between the two national societies can be nullified.

V. Public Health:

1. *Death* and the *Physicians and the Dying Patient* were two reports of major importance from the Judicial Council. A legal definition of death was eschewed.

2. Informed Consent (Bd. of T. Rept. X):

   This comprehensive and detailed report announced a preparation of material from the Office of General Counsel of the AMA for helpful guidance for physicians and state and county societies. The OGC is at work preparing abstracts of court decisions which indicate the scope of informed consent in the various jurisdictions.

VI. Miscellaneous:

1. Economic Stabilization Phase IV Constraints:

   There were many resolutions, including Res. 16 from Michigan, and two lengthy reports which called for more aggressive action from the AMA anent Phase IV. Report AA and BB of the Board of Trustees summarized the history of price controls on physicians and hospitals with past, present, and continuing activities to solve the problems thereto. Res. 16 from Michigan called for immediate court action — it was favorably received at the Reference Committee. Litigation has since been initiated by the AMA.

2. *Financing Medical Education* (CMS-G):

   This is a very comprehensive progress report with major input from the AMA staff, Councils, and SAMA on past and present student financial assistance activities and discussing the advantages and disadvantages of loan forgiveness. It supports expansion of all effective methods of financing of individual medical education.

With the above a too brief report of the Clinical Session of the AMA 1973, your delegation makes and supports the following recommendations to this Council:

RECOMMENDATION I—That The Council of MSMS adopt as policy Report EE as amended re PSRO and continue efforts for repeal of PL 92-603 while simultaneously exerting leadership with constructive suggestions for amendments to PL 92-603 coupled with aggressive efforts to develop appropriate rules and regulations.

RECOMMENDATION II—That The Council of MSMS notify constituent county officers of this policy as consistent with and supportive of Resolution 73A-2 of the House of Delegates, MSMS (Repeal of PSRO Amendments).

RECOMMENDATION III—That The Council of

MSMS support the candidacy of John Moses, MD, for nomination to a position on CME, AMA to be presented to the House of Delegates at the Annual Session 1974, and that appropriate letters be forwarded promptly to the BOT AMA and that if nominated, the proper financial assistance be given the Delegation to insure his election.

In closing, I wish to commend and thank the members of the Michigan Delegation for the hard work that they put forth for this Society. No group in my memory has worked more diligently, more hours, and more effectively.

We also would like to commend and thank Mssrs. Tryloff, Ambrose and Campau for their help — without which nothing would have been accomplished.

And last but certainly not least we thank — and call to your attention — the ladies of the delegation who under the Chairladyship of Doris Coury ran the hospitality suite at each of our open houses.

8. Report to the MSMS House of Delegates by the MSMS Committee on Planning and Priorities about MSMS committee work

Committee Recommendation: That the House of Delegates gives general approval to a proposal that MSMS committee work be strengthened by logically grouping committee subject matter into "divisions" and that the House instruct the Committee on Constitution and Bylaws to prepare the necessary amendments for consideration at the next meeting of the House of Delegates.

The MSMS Committee on Planning and Priorities has chosen to present two separate reports with recommendations to the 1974 Session of the MSMS House of Delegates. This report deals only with MSMS Committee work. Another report covers several other aspects of MSMS structure and operation.

It is the conviction of the Committee members that the several subjects under study should be divided into the two reports to enable the members of the House of Delegates to better understand the proposals and to deal more systematically with the two sets of recommendations.

The Committee on Planning and Priorities presented a number of suggestions to the 1973 Fall Session of the House of Delegates. The House instructed the Committee to disseminate its proposals to component medical societies for review, discussion and comment. The House instructed the Committee to report to the Spring Annual Session.

The Committee has found little objection to the proposals to restructure the MSMS committee work.

The MSMS Council on March 13, 1974 adopted a report of its ad hoc subcommittee to review the recommendations of the Planning and Priorities Committee. That report said in part, "The Subcommittee members believe the intent of the proposed changes for committee work would improve the study of concerns and projects, and would streamline committee work for greater efficiency." (The Chairman of The Council had appointed six Council members to study the recommendations of the Planning and Priorities Committee and report back prior to the spring 1974 meeting of the House.)

MSMS COMMITTEES HAVE BEEN UNDER STUDY SINCE 1969:

The need to evaluate the MSMS committee work has been expressed for many years. Back in 1969, the MSMS Council appointed the first Committee on Planning and Priorities which held several meetings in 1970 and 1971 to study the purposes and activities of the many MSMS committees. Each of the committee chairmen were asked to present a written report and to identify purposes and to explain activities and accomplishments. The work was well underway when The Council employed the Alexander Grant firm of Detroit in 1971 to conduct a survey of member attitudes and opinions. Questions were asked about committee operations, MSMS services, etc.

The House of Delegates at its Spring 1972 meeting reviewed the Alexander Grant (Phase II) Report. The House asked the MSMS Committee on Planning and Priorities to review the Report and its recommendations. The committee was enlarged to provide better geographic representation and to provide representation from the House, from The Council, for the specialty societies, from medical students, from interns and residents, etc. The expanded committee met in February, 1972 and established two work groups — one to deal with committees and one to consider member services. After several meetings of the work groups of some indepth study, they were discontinued and since then the full Committee has held regular meetings.

Committee members have asked many questions, such as "What committees should MSMS have?" "Should MSMS continue to have committees appointed by the President, by the Chairman of The Council, and by the Speaker of the House?" "What might be done to eliminate the overlapping of committee work?" "How can the MSMS professional staff be most valuable in providing staff assistance to committees?"

PROPOSED "DIVISIONS" WOULD IMPLEMENT PURPOSES, OBJECTIVES:

The MSMS Committee on Planning and Priorities decided that before the questions about committees could be logically discussed, the House of Delegates first should review the MSMS purposes and then should adopt some general objectives. The point was made that MSMS should recognize the architectural principle that "form should follow function."

The Report of the Committee on Planning and Priorities to the 1973 Spring House of Delegates suggested some minor updating in the "Purposes" of MSMS as spelled out in the MSMS Constitution. The House concurred in the changes and these were approved on first reading at the 1973 Fall meeting of the House.

The 1973 Spring report also asked the House to identify nine current objectives for MSMS, and 12 intermediate, longer-range objectives. The House approved the lists and gave them to The Council to implement.

The Planning and Priorities Committee had agreed that, if the House would update the purposes and identify major areas for MSMS activity, then the Committee

would find a good way to structure the organization for effective committee action.

So after the House action in the spring of 1973, the Planning and Priorities Committee decided to group the purposes and objectives into areas of similarity. Some of the goals were in the area of legislation and socio-economics, some dealt with public and community service, others with health care delivery, others with medical education, and some with MSMS services to members. The suggestion was made that MSMS should establish a number of "divisions" in order to coordinate and consolidate study and action in understandable, visible thrusts.

DIVISION PROPOSAL WOULD CORRECT PRESENT SHORTCOMINGS:

Committee members also saw the opportunity to develop some new practices and procedures that would correct or minimize some of the former weaknesses in MSMS committee work.

It was suggested that rather than have overlapping committees appointed by the President, by the Council Chairman, and by the Speaker of the House, that it would be more logical for the overall, parent committee for each division to include: 1) members of the House, 2) members of the MSMS Council, and 3) members at large.

There was agreement that some new approach should be developed to facilitate communication between The Council and the working committees. It was suggested that the chairmen of the divisions should be members of The Council, in order to facilitate both up and down communications. It was recognized that, while this might be ideal, there might be an occasional exception.

Committee members, in reading the annual reports of the MSMS committees, found that some committees rarely met and some seemed to be ineffective. Committee members felt that MSMS should make much more use of specially appointed task forces to handle a specific assignment and then to be disbanded.

Committee members recognized that to a large degree now, the committees tend to be grouped into such areas as Legislation or Communication, thus following the new MSMS staff structure with its departments, for example, of Government Relations, and of Communication. By dividing major committees logically among the MSMS staff departments, MSMS now has knowledgeable, competent staff assistance for the MSMS major committees. This procedure permits the MSMS professional staff to operate under the "management by objectives" principle.

HERE ARE BASIC CONCEPTS FOR PROPOSED DIVISION APPROACH:

The following concepts would apply to the divisions for MSMS committee study and action, and would not apply to the operating committees that the MSMS Council would be permitted to continue. The Council needs such operating committees as Finance, Legislative Policy and Scientific and Educational Affairs as provided for the MSMS Bylaws.

Concepts for Divisions:

1. MSMS objectives should be grouped into areas of common interest and Divisions should be established to coordinate and implement MSMS study and action to accomplish the assigned goals.

2. Each Division should be led by a committee of 10 to 30 members, appointed by the Council Chairman with the concurrence of The Council. Division members shall be appointed to serve 3-year terms, and not more than 3 terms. Each Division Committee would include two or more members of The Council and five or more members of the House of Delegates.

3. Each division, in deciding how best to accomplish its responsibilities, would establish ongoing permanent subject-matter committees (such as the Committee on Maternal and Perinatal Health) and Ad Hoc Task Forces to study appropriate matters, to make recommendations to The Council, and to recommend possible changes in policy to the House through The Council. These permament, standing-type committees and Ad Hoc Task Forces would be appointed by the Chairman of The Council with the concurrence of The Council. The Division chairmen will be invited to recommend members for appointment. The present practice of requesting component medical societies and Council members to suggest members for possible appointment should be continued.

4. The Chairman of The Council, with the approval of The Council, shall appoint the Division chairmen. The members of the Planning and Priorities Committee see advantages in having a member of The Council if interested and qualified serve as chairman of each Division, but recognize that this should not be a mandatory requirement.

5. The Division would meet at least twice a year, once to develop its own action program to be submitted to The Council for approval, and later to monitor progress.

6. The Council may assign subjects for study to the Division chairmen. The Division chairmen may assign the matters to a committee or task force and request a report and recommendation back to the Division, with a copy to the Chairman of The Council. The Division will report to The Council.

SUGGESTED APPROACH TO CHANGES IN BYLAWS TO PROVIDE FOR DIVISIONS:

The present MSMS Bylaws contain several sections dealing with MSMS committees. Chapter 10 (in addition to discussing the operating committees of The Council) outlines the procedure for The Council Chairman to appoint special and ad hoc committees. Chapter 12 deals with standing committees of the Society and for the appointment of such committees by the President. Twenty-three specific committees are mentioned

The Committee on Planning and Priorities suggests that the Committee on Constitution and Bylaws write a new chapter dealing with the Division approach. The concept should be established and procedures spelled out for the appointments, flow of communications, etc. The Committee would advocate that the Bylaws should not set into concrete the names for any specific divisions, but would permit The Council to make necessary modifications in the future as conditions might warrant.

EXAMPLES OFFERED TO ILLUSTRATE HOW DIVISIONS WOULD WORK:

The following material is intended to help delegates

visualize and understand how the MSMS purposes and goals might be grouped into divisions of responsibility. The Committee does not intend that the following would be written into the possible changes in the Bylaws, but that the following would be considered by The Council in establishing what would seem to be logical division. The Committee has used the following as its working model:

DIVISION 1: LEGISLATION AND SOCIO-ECONOMICS

To Implement the following MSMS Purposes and Objectives:

To stimulate advancement of the . . . economic and medical political knowledge of its members in order that the doctor may better serve his patients and the public health generally.

To advocate fair remuneration for services rendered.

To seek solution to Medicaid problems.

To develop and support MSMS policies re current legislation.

To introduce legislative measures to alleviate professional liability insurance problems.

To conduct and evaluate MSMS sponsored practice management seminar on a pilot basis.

To explore and determine the proper MSMS role in matters of state and federal funding of medical and health services.

To initiate a more effective informal liaison with Michigan Medical Services.

(Note: Each division would have Standing Committees and Ad Hoc Task Forces)

DIVISION 2: MEDICAL ORGANIZATION AND SERVICES TO MEMBERS

To Implement the following MSMS Purposes and Objectives:

To constitute, support and advise the American Medical Association in cooperation with similar societies of other states, in meeting its appropriate responsibilities.

To charter and organize constituent component medical societies.

To encourage medical students and physicians-in-training to participate in organized medicine in order to enable MSMS to be representative of all physicians.

To institute and provide specific services to meet the needs of the members.

To increase assistance to components in membership retention and recruitment.

To develop program of member assistance.

To encourage and assist component medical societies so they can take active role in community health related programs such as area-wide planning.

To conduct opinion surveys of MSMS membership on important issues.

(Note: Each division would have Standing Committees and Ad Hoc Task Forces)

DIVISION 3: PUBLIC SERVICE AND COMMUNITY RELATIONS

To Implement the following MSMS Purposes and Objectives:

To conceive, develop and administer health education programs designed to improve public understanding, awareness and acceptance of good medical standards, practices and concepts, as they relate to personal health, scientific progress and society's advancement.

To provide medical leadership in meeting the health needs of the people by working with other medical and non-medical groups and individuals.

To enhance physician-patient relationships, as basic to the delivery of quality health care.

To ensure the adequacy of medical manpower by recruiting capable people into the medical and health professions.

To support efforts of those who would enhance the reputation and services of the medical profession.

To carry forward the five present MSMS public relations projects, which are VD Education, Education about the Medical Aspects of Pollution, Chiropractic Education, Work to Make Medical Assistants More Effective Communicators, and Help People Find a Doctor, and to especially concentrate on projects to educate both the physician and the public about chiropractic.

To continue to improve techniques and methods of communicating with the members and the public; and to encourage communication from the members to MSMS.

(Note: Each division would have Standing Committees and Ad Hoc Task Forces)

DIVISION 4: HEALTH CARE DELIVERY

To Implement the following MSMS Purposes and Objectives:

To promote quality medical and health care by development and support of activities appropriate to this goal.

To ensure the adequacy of medical manpower by improving the effective distribution of medical and health professionals.

To monitor and coordinate development of PSROs in Michigan.

To create medical care guidelines for adoption by regional PSROs.

To study the trends of utilization of emergency rooms and recommend appropriate MSMS involvement.

To develop concepts and models of ambulatory care systems so physicians can provide leadership in this matter.

To begin efforts to involve MSMS in MD Placement Activities.

To encourage and assist component medical societies so they can take active roles in community health related programs such as area-wide planning.

(Note: Each division would have Standing Committees and Ad Hoc Task Forces)

DIVISION 5: STUDY OF HEALTH PROBLEMS AND CONTINUING EDUCATION

To Implement the following MSMS Purposes and Objectives:

To stimulate advancement of the science and art of medicine and continually to seek to advance the medical, scientific, social, environment . . . knowledge of its members in order that the doctor may better serve his patients and the public health generally.

To promote quality medical and health care by development and support of activities appropriate to this goal.

To foster and support continuing medical education.

To develop continuing medical education certification plan for Michigan.

(Note: Each division would have Standing Committees and Ad Hoc Task Forces)

AND, IN SUMMARY

The Committee on Planning and Priorities feels that it is urgent that MSMS act now to improve its committee work. The present practices have continued for many years. The proposal that MSMS establish a division approach recognizes some of the evolutionary changes that have already been started by MSMS leaders, and it parallels similar changes made in recent years by other state medical societies and other organizations. Many organizations are consolidating committees into divisions or commissions — partly in order to pinpoint responsibilities and to maximize wise use of volunteer hours, staff and finances.

Committee members appeal to the House of Delegates: 1) to approve, the division approach in general, and 2) to be prepared at the next meeting to amend the MSMS Bylaws to establish divisions.

REFERENCE COMMITTEE A, John C. Benson, MD, Chairman, recommended the approval of the report of the Planning & Priorities Committee re MSMS committee work to reorganize the present 56 MSMS committees into five divisions and urged its expeditious implementation.

THE HOUSE adopted the report of the Reference Committee.

9. Report to the MSMS House of Delegates from MSMS Committee on Planning and Priorities about MSMS Elections, House of Delegates, Components.

Recommendation: That the House of Delegates gives general approval to several proposals and that the House instruct the Committee on Constitution and Bylaws to prepare the necessary amendments for consideration at the next meeting of the House of Delegates.

The recommendations, which are free-standing and can be considered individually, would provide for:

1. The election of the president-elect and secretary by mail vote by all regular members from a slate of nominees to be presented by a nominating committee.

2. Several changes in the House of Delegates operations, dealing primarily with the establishment of a maximum, continuous term of service for a delegate.

The Committee on Planning and Priorities also presents some comments here about component societies.

The Committee also reports on the several major areas of ongoing consideration.

* * *

The MSMS Committee on Planning and Priorities has chosen to present two separate reports with recommendations to the 1974 session of the MSMS House of Delegates. This report covers several aspects of MSMS structure and operation. The other free-standing report deals only with recommendations about MSMS committee work.

* * *

PART A: ELECTION OF PRESIDENT-ELECT AND SECRETARY

The MSMS Committee on Planning and Priorities, since it was enlarged after the spring meeting of the House of Delegates in 1972, has discussed possible ways to make MSMS more democratic and to provide more opportunities for each and every member to participate in some of the official business affairs of MSMS.

Professionals who study such related areas as association structure, organizational management, group action, adult motivation, etc., report that much research has proven that members will be more active in organizations that permit them to participate, and will be more loyal to the efforts of such organizations. There has been a trend by professional and trade associations to remove former restrictions in order to permit members a direct vote for the major officers.

Members of the Planning and Priorities Committee feel strongly that every member in good standing should be afforded the opportunity to help select the president-elect of the State Medical Society. Members are provided this opportunity in the component medical societies — Wayne County Medical Society sends a ballot to all members with the names of two or more candidates for president, and other societies generally hold the annual election at a membership meeting.

The general idea was proposed by the Planning and Priorities Committee as part of its report to the 1973 House of Delegates. At the reference committee hearing held during that session of the House, the strongest opposition to the every-member-a-voter concept came from several past presidents.

A survey questionnaire was mailed by the Planning and Priorities Committee to every MSMS delegate in March and the views expressed on the subject of electing the president-elect were inconsistent and inconclusive. Only 79 of the 219 delegates returned their questionnaires. The Planning Committee members were disappointed in that only one of three delegates expressed his opinion. The committee doubts if the views of the one-third can be considered truly representative.

The Planning Committee, at its March 27 meeting, considered the position taken by the MSMS Council to oppose the proposed direct election of the president-elect. The Committee likewise considered the results of the opinion poll taken at a regular membership meeting of the Ingham County Medical Society where the vote was 3 to 1 in favor of direct elections.

Committee members favor the direct election of the president-elect and secretary, so felt that the matter

should be taken to the floor of the House of Delegates for discussion, possible modification, and hopefully for approval.

Some of the committee members, who have appeared before component societies to talk about the Planning Committee recommendations, report that some concern had been expressed about the small size of the proposed nominating committee. So the Planning and Priorities Committee on March 27 voted to enlarge the nominating committee from 6 to 9. The Committee also voted to propose a system that would guarantee good geographic representation on the Nominating Committee. Those details follow later.

The Planning Committee on March 27 was impressed with the logic of a proposal voiced in the written report from the Washtenaw County Medical Society to the MSMS Committee on Planning and Priorities. [The 1973 Fall House of Delegates requested the Committee to invite components to study the issues and to file a written report by Feb. 1, 1974. The Committee on Dec. 6, 1973 wrote each component society president inviting such grass-roots involvement. The Committee received written reports only from Washtenaw County Medical Society (commenting on all the issues) and from the Marquette-Alger County Medical Society (commenting on only one issue).]

The communication from the Washtenaw president said, "We favor the one-man-one-vote principle and the concept of multiple nominees for office. The MSMS president-elect and secretary should be elected by a mail vote. The treasurer should have expertise in his area and therefore, he should be elected by the board of directors."

The Planning and Priorities Committee concurs in these views about the treasurer. The Committee, in its detailed recommendations below about elections, proposes that the members elect the president-elect and secretary, but not the treasurer. This is a change from the Committee's 1973 fall suggestion that the treasurer also should be elected by a mail vote.

Following are the detailed proposals for this Part A dealing with the election of the President-Elect and Secretary:

1. The President-Elect shall be elected by mail vote of the membership.

2. There shall be a Nominating Committee consisting of 3 members of the House appointed by the Speaker, 3 members of the Council named by the presiding officer, and 3 members at-large appointed by the President. In order to insure geographic representation on the Nominating Committee, the state shall be divided into three areas of approximately equal membership, Areas AA, BB and CC. Each of the appointing officers shall select one member from each of the areas. (The map showing the three areas and listing the component societies in each is attached as Addendum A). The committee shall elect its own chairman.

3. The Nominating Committee shall invite component medical societies to submit the names of possible nominees. The Nominating Committee shall submit the names of at least two physicians for the office of president-elect. A candidate also may be nominated by petition containing the names of at least 350 MSMS members including at least 25 from at least 13 component societies. The permission of each candidate must be obtained before the ballot is mailed. Three physicians shall be appointed by the presiding officer of the Board to serve as tellers. Election shall be by plurality.

4. The Secretary shall be elected by vote of the membership, following the same procedure as described for the president-elect. The secretary shall be eligible for re-election. The secretary shall continue to be a voting member of The Council.

5. The Treasurer shall be appointed annually by the MSMS Council for a one-year term. At the time of selection, the treasurer need not be a member of The Council. The treasurer shall continue to be a voting member of The Council.

6. The current procedure of appointment by The Council of an assistant secretary and an assistant treasurer shall be continued.

7. The Council shall continue to elect its own chairman and vice-chairman.

* * *

PART B: HOUSE OF DELEGATES

The Planning and Priorities Committee commented on several aspects of the MSMS House of Delegates in its report to the 1973 fall meeting.

The Committee on March 27, 1974 studied the reactions of the MSMS Council, the views expressed by the delegates who returned their questionnaires, and comments from other sources. The Committee decided to clarify its position on subjects relating to the House of Delegates:

1. The House of Delegates shall continue as the policy-making body. The present provisions for representation from the component societies, sections, SAMA chapters and for seating of the deans of medicine if members should be continued. (Attention is directed to comments later about the need to evaluate the present procedure for electing delegates to provide input to the House from the various specialties). These comments coincide with the position of the MSMS Council taken on March 13.

2. The House of Delegates will no longer need to have study committees of its own in the future, because by adopting the proposed MSMS Divisions, each committee responsible for the operation of a Division would include members of the House as well as members from The Council and the general membership. In the future, it would be general policy for the House of Delegates to refer matters to The Council (which would refer on to the Divisions) asking for a report and recommendations back to the House. The Council adopted an amended motion March 13 which seems to favor a general House practice of referring matters to The Council, but permitting the House to have its own study committees under certain conditions. The Committee does not accept the Council's views.

3. The House should establish 10 consecutive years of service as the maximum continuous tenure for delegates. Delegates may be seated again after a break of at least one year. The MSMS Council does not agree with this position. The Committee members feel it is essential that more MSMS members be permitted the opportunity to serve as a member of the House of Delegates and

thus participate in the experience of establishing MSMS policy. The Committee members are certain there are many qualified, active members who would welcome the opportunity to serve as a delegate.

* * *

PART C: COMPONENT SOCIETIES

The Planning and Priorities Committee spent considerable time discussing the MSMS component societies and possible ways to reorganize or restructure the "local units." The Alexander Grant Study advocated dissolving all the components and chartering "chapters" with both minimum and maximum membership limitations. The Committee also considered the possibilities of merging smaller units with neighboring components. Likewise, there has been discussion about the possibilities of dividing one or more of the components with large memberships. While some members felt the county boundary lines have less relevance today for medical societies, other members contended that the county boundaries indeed are valid and important.

Committee members agree that components should be urged to evaluate their present effectiveness and should voluntarily consider possible changes.

The Planning and Priorities Committee requests the House of Delegates to concur in the following statement about components:

> No specific amendments are proposed at this time to make any changes mandatory re the present component medical societies. The Committee does respectfully recommend that each component society examine its size and operation toward maximizing the opportunities for each member to participate effectively in the operations of the component society. The smaller component societies are encouraged to consider possible advantages in joining with adjacent components in order to have more effective scientific meetings, in order to strengthen programs in legislation, etc. The larger component societies are encouraged to consider subdivisions in order to accomplish the same desirable goals.

* * *

PART D: MATTERS UNDER CONTINUING STUDY BY THE COMMITTEE

The Planning and Priorities Committee wishes to report to the House that it is continuing its evaluation of a number of subjects, and plans to offer more recommendations at the next meeting of the House. Subjects under study include the following:

1. *Matters relating to The Council (or the Board of Directors):*

The Committee made a series of recommendations to the MSMS House of Delegates in the fall of 1973 about possible changes in the composition of an election to The Council. There was no opposition voiced to a suggestion that the MSMS Council should be called a "Board of Directors" to better describe its actual role. The Committee plans to make such a recommendation in the future, but that item alone is of relatively low priority. The 1973 fall recommendations, 1) to change the boundaries for the Councilor Districts, 2) to equalize the number of Council members from the Districts depending upon MSMS membership in each district, and 3) to add 5 non-MD lay members to the board were all opposed by the MSMS Council March 13, 1974 and by some other voices that were heard at component meetings and through surveys. The Committee on March 27 decided to continue its study of these ideas and others during the coming year, partly to see if the possible formation of and operation of PSRO areas will have any relationship to the MSMS councilor districts or any impact on the organization of the MSMS Council.

2. *Matters relating to the MSMS Delegation to the AMA:*

The Committee made a series of recommendations to the MSMS House in the fall of 1973 about possible changes in the election procedures for the Michigan delegates to the AMA House. The substantial recommendations were opposed by the MSMS Council and by members of the present delegation to the AMA. The Committee has not had an opportunity to review those stands taken on March 13. The matters will be considered further in coming months.

3. *Matters relating to the election of delegates from the MSMS sections to the MSMS House of Delegates:*

The MSMS Council on March 13 requested the Planning and Priorities Committee "to consider other methods of determining section delegates." The Planning and Priorities Committee on March 27 heard a representative of The Council of Specialty Societies recommend that the present sections be disbanded and replaced by the Michigan chapters of the national specialty organizations that are now recognized by the AMA. Committee members asked the Council of Specialty Societies to consider the matter further and to present specific details about election procedures, about voter prerequisites, etc. Committee members agree generally that this entire matter should be studied in depth, because now that each section delegate has a full vote in the House, the way in which they are chosen becomes of greater importance than before when each section delegate could only talk on the floor, but could not vote. The same overall question is scheduled for debate at the AMA House of Delegates in June and that outcome will be considered, too, by the MSMS Planning and Priorities Committee.

4. The Committee also is studying several specific requests made by the MSMS Council.

* * *

In closing, the MSMS Planning and Priorities Committee requests the House of Delegates to give consideration at the May, 1974 meeting to proposed changes regarding the election of the president-elect and secretary, and regarding length of terms for members of the House of Delegates.

The Committee also urges the delegates to agree that the proposed changes in the election of the president-elect and secretary, and regarding length of terms for members of the House of Delegates.

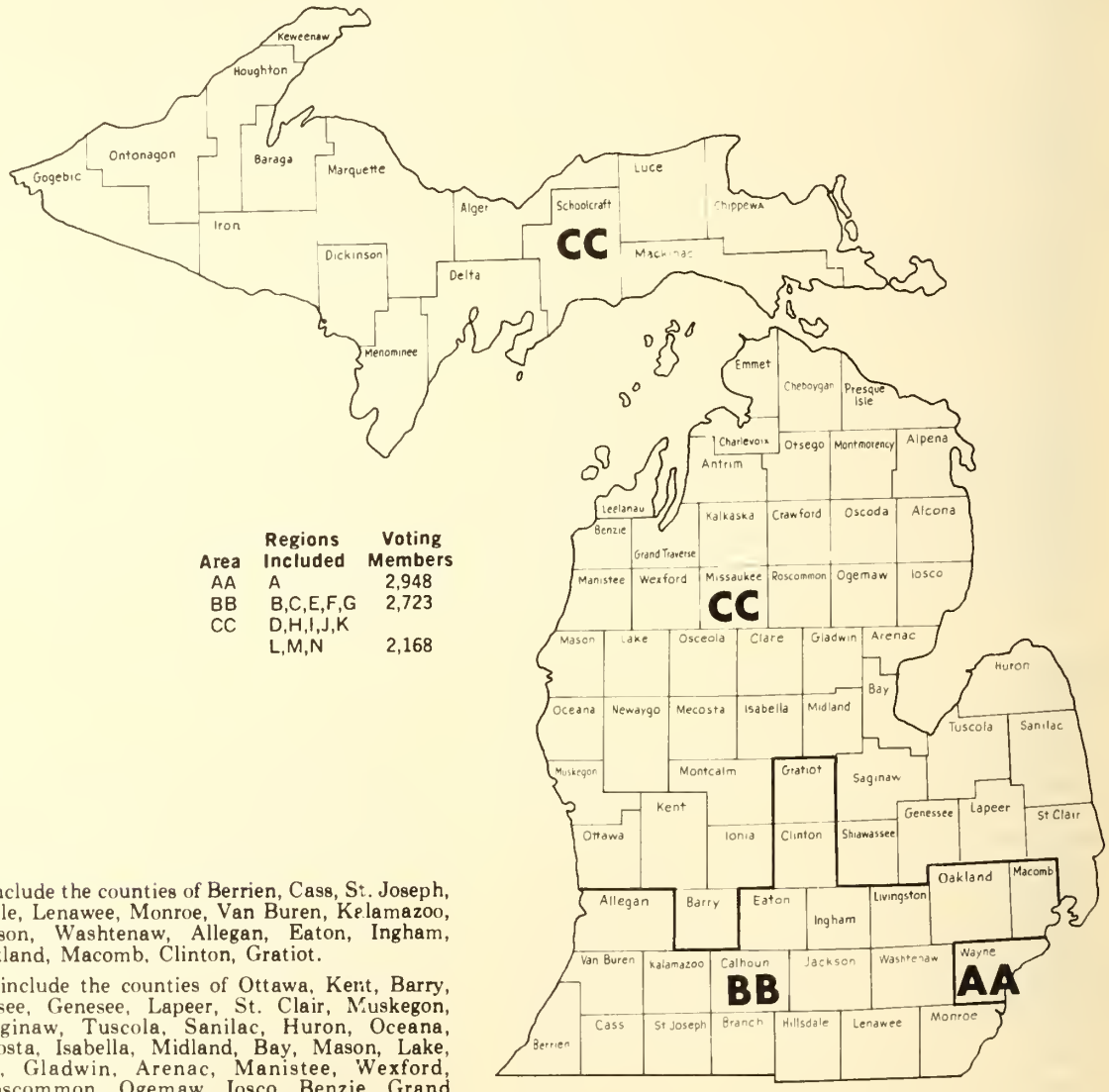
The Committee also urges the delegates to agree that the proposed changes in the election of the president-elect and secretary and the several changes dealing with the House should be put into language by the MSMS Committee on Constitution and Bylaws for consideration in depth at the next meeting. Meanwhile, the issues can be discussed further by members of the components, by the MSMS Council, etc. To defer consideration of this report, it seems to the Committee, would be reac-

tionary and unfortunate. Times and conditions are constantly changing and present approaches should be reviewed and reconsidered.

Members of the MSMS Committee on Planning and Priorities are sincerely interested in making the overall medical society work more effectively to serve both the medical profession and the public. Members are agreed that changes should not be proposed merely for the sake of change. Committee members do feel that the changes proposed in the two reports to the 1974 House should be considered seriously by members of the medical society and by their elected representatives serving as the MSMS House of Delegates.

Map to be used for the appointment of members of the MSMS Nominating Committee.

In order to insure geographic representation on the Nominating Committee, the state shall be divided into three areas of approximately equal membership, Areas AA, BB, and CC. Each of three appointing officers shall select one member each of the areas; thus the Nominating Committee of 9 members shall include three members from Area AA, three from BB and three from CC.



Area	Regions Included	Voting Members
AA	A	2,948
BB	B,C,E,F,G	2,723
CC	D,H,I,J,K L,M,N	2,168

Area BB shall include the counties of Berrien, Cass, St. Joseph, Branch, Hillsdale, Lenawee, Monroe, Van Buren, Kalamazoo, Calhoun, Jackson, Washtenaw, Allegan, Eaton, Ingham, Livingston, Oakland, Macomb, Clinton, Gratiot.

Area CC shall include the counties of Ottawa, Kent, Barry, Ionia, Shiawassee, Genesee, Lapeer, St. Clair, Muskegon, Montcalm, Saginaw, Tuscola, Sanilac, Huron, Oceana, Newaygo, Mecosta, Isabella, Midland, Bay, Mason, Lake, Oscola, Clare, Gladwin, Arenac, Manistee, Wexford, Missaukee, Roscommon, Ogemaw, Iosco, Benzie, Grand Traverse, Kalkaska, Crawford, Oscoda, Alcona, Leelanau, Antrim, Otsego, Montmorency, Alpena, Charlevoix, Emmet, Cheboygan, Presque Isle, Gogebic, Ontonagon, Houghton, Keewenaw, Baraga, Iron, Dickinson, Marquette, Menominee, Alger, Delta, Schoolcraft, Luce, Mackinac, Chippewa.

REFERENCE COMMITTEE C, George Porretta, MD, Chairman, considered the report of the Committee on Planning & Priorities about MSMS Elections in three parts:

Part A — The Committee recommended the House disapprove the proposal that the president-elect be chosen by mail vote of the membership and continue the present procedure of having the House of Delegates choose the president-elect. The Committee recommended the House approve the proposal that two or more nominees be offered for the office of president-elect and that the MSMS Committee on Constitution and Bylaws be instructed to develop implementing language that this House could consider at its next meeting.

The Committee recommended that there be no change in the current selection of the Secretary, Treasurer, Assistant Secretary, Assistant Treasurer, Chairman of The Council and Vice-Chairman of The Council.

Part B — The Committee recommended disapproval of the proposal to establish 10 years as the maximum continuous tenure for delegates.

Part C — The Committee recommended approval of the statement that "No specific amendments are proposed at this time to make any changes mandatory re the present component medical societies." The Committee also recommended approval that each component society examine its size and operation toward maximizing the opportunities for each member to participate effectively in the operations of the component society. The smaller component societies are encouraged to consider possible advantages in joining with adjacent components in order to strengthen programs in legislation, etc. The larger component societies are encouraged to consider subdivisions in order to accomplish the same desirable goals.

THE HOUSE adopted the report of the Reference Committee.

10. Report of the Medicaid Liaison Committee — James D. Fryfogle, MD, Chairman

This Committee was organized pursuant to Resolution 73S-31 to maintain a continuing liaison with the Department of Social Services.

The Committee met with the Department's administrative personnel, including R. Bernard Houston, director of the Department and Donald C. Smith, MD, advisor to the Governor on health and medical affairs on Aug. 29, Nov. 14, 1973, Feb. 13, 1974 and has scheduled meetings for May 15 and Sept. 11, of this year.

Liaison functions on two premises . . .

Complaints by physician members of MSMS about Department handling of claims are laid on the table for discussion. Many of these complaints are resolved through this process. Others still remain open for resolution and are discussed at each subsequent meeting.

Second process is where matters of mutual concern of the Department and the MSMS Liaison Committee are brought up by either party.

Issues open at this time include new coding for pediatric intensive care units, resolution of ophthalmology-optometry issues, and more adequate reimbursement for certain procedures, and others.

The Committee believes that, in general, the liaison is a healthy one and that the House of Delegates was very wise in adopting Resolution 73S-31 last Spring to create this Committee.

11. Report of the Ad Hoc Committee on Medical Care Delivery — Robert E. Rice, MD, Chairman

The report of this Committee's deliberations is in the Speaker's Report. This concerns three resolutions that were referred to the Committee: 73A-31 A Single Plan for Medical Care Insurance; 73A-32 Governmental Role in Financing Medical Indigents and 73A-33 Medical Care Delivery to the Needy.

This Committee included Sidney Chapin, MD; Bonta Hiscoe, MD; Robert Jardinico, MD, and George McGill, MD, who were present at the meeting. Also named to the Committee but who were unable to meet with the Committee were Norman Bolton, MD; Eli Igna, MD, and John Wood, MD. We had some lively discussion the evening we met about this, and we came to the conclusion, as you see, that MSMS does not have the manpower or the money to accomplish the task that was assigned in these resolutions. We do not think we are against the idea, but at the moment these could not be implemented, and I thought I should explain that to you.

We thought we were in a fortunate position, in that at about the time this Committee was formed there was a conference to be held in Washington on Health Care of the Poor, which I was to attend and hopefully get some basic ideas which we could use as a springboard without spending so much time and staff time and money. However, that meeting in Washington was called off, and so we had to have our meeting without any of the ground work, and it was felt that for the moment it would be best not to proceed this year with this.

This does require a lot of work. I do think the idea should be referred to one of our reference committees this year, to see if they want to proceed with how we would handle this problem as it goes on. Some of the things that were mentioned in it are presently being considered in bills before Congress as they apply to national health insurance. Whether we need to have separate, detailed input, I don't know. I wish this House would discuss this in one of the reference committee meetings, and then we can decide how to proceed.

REFERENCE COMMITTEE B, Charles E. Darling, MD, Chairman, recommended these resolutions be referred, without action, to the delegation to the American Medical Association with instructions to use these resolutions as a basis for proposals to the next meeting of the House of the AMA.

THE HOUSE adopted the report of the Reference Committee.

12. Report of the Michigan State Medical Society Auxiliary — Mrs. William J. Jones, President

(Presented in written form.)

The Auxiliary to the Michigan State Medical Society started off by changing its name to the Michigan State Medical Society Auxiliary at the Fall Convention, 1973. We elected to keep the name as it has been until after our 50th Anniversary celebrations in 1976-1977. Both names may be used at this time though.

The other major change was to hold our Annual Meeting in the spring of the year, rather than the fall of

the year. This change makes it easier to conform with WA-AMA program and with the county medical society programs. For this year only the state officers and chairmen will hold office until the annual meeting on May 5-7, 1975 at the Troy Hilton in Troy, Michigan.

Membership has dropped considerably this year and Menominee County Medical Society Auxiliary has disbanded. At present there are five counties with 100% membership: Gogebic, Huron, Muskegon, Newaygo, and Sanilac. There are 35 organized counties with a total membership for the state of 2,819; for national of 2,770. Because dues are not due until later this year, this may not be an accurate figure. There are 56 members-at-large.

WA-AMA had two programs that they urged us to promote, with special emphasis on Child Abuse:

HEALTH ACTIVITIES	*HEALTH EDUCATION*
1. Children & Youth	1. Mental Health
2. GEMS & Block Mother	2. Ecology
3. Blood Donor	3. Aging & Homebound
4. Safety	4. Nutrition

The Telstar I program was carried over this year also: Tel-a-phone Reassurance, Tel-e-vision, Tel-a-parent, Tel-a-newcomer, Tel-an-intern.

The Telstar II program is a more individual program so that, hopefully, members who are not too active could also participate. The theme for this year is *KEEPING UP WITH THE JONESES,* and in so doing each member can say *My Service Means Something.* Tel-a-patient you will urge members to sign organ donor cards and donate blood. Tel-a-doctor you love him is the day to tell all doctors how much they mean to us. This is March 30th, so chosen to commemorate the day that Dr. Crawford W. Long first used ether as an anasthetic. Tel-a-legislator is to urge women to become vitally interested in medical legislation and take an active part. Tel-a-member you are a friend is the adoption plan to make members-at-large feel more at home at our meetings. Tel-a-family you care is the effort we are making to see that all physicians' wives have a physical examination this year. We will hold a lottery at Convention '75 of those who have had their physical examinations.

Contributions to AMA-ERF totaled $16,300.95 which gave us $5.08 per member. We are hoping that this amount will give us a National award. (Figures given are as of April 1, 1974.)

State officers have attended President — President-Elect Conferences in Chicago; North Central Workshops in Cincinnati, Ohio; AMA Leadership Conference in Chicago; County Leadership Seminar in Chicago; AM-PAC meetings in Washington, D.C.; Quality of Life Conference in Chicago; Rural Health Conference in Detroit; conventions in Wisconsin and Ohio; the Medical Assistants' Convention; and many county meetings.

Meetings were held in six districts in the fall, giving the counties all the materials that we received at the National meetings. Legislative Day/Spring Leadership Conference is April 24-25, 1974. Mrs. John Chenault, AM-PAC liaison, Brooker L. Masters, MD, and Bruce Ambrose will be guest speakers at Legislative Day. Our Senators and Representatives will be our guests at luncheon. At Spring Leadership Conference, our guest speakers will be Mrs. Max Olsen, Bruce Danto, MD, Mrs. Fleming Barbour, Mr. David St. Clair, and Robert Levine, MD.

Our Health Careers Chairman serves on the Michigan Health Council. We are represented on the MSMS Legal Affairs Committee by our Legislative Chairman, and two members serve in an advisory capacity to the MSMS Committee on Public Relations.

Under International Health, we have collected hundreds of eye glasses for the Dominican Republic; 45,000 pounds of pharmaceuticals which were given to World Medical Relief for distribution. Members also participated in Project Concern and SKIP.

Several counties now have Mobile Meals programs which serve hot and cold meals every day to shut-ins.

The Auxiliary to the Michigan State Medical Society is "Keeping Up with the Joneses" and each member can proudly say My Service Means Something!

13. Report of the American Association of Medical Assistants, State of Michigan — Mrs. Audrie Chute, CMA, President

(Presented in written form.)

Serving as President of AAMA, State of Michigan this last year has been a challenging experience. During the months of fulfilling the duties of this office, the contacts have been rewarding and most pleasurable.

Our membership has not grown to the level of our potential. We have had the support and encouragement of the doctors through the efforts of Herb Auer, MSMS Director of Communications, and the Council of MSMS. The challenge to increase our membership further rests with the local chapters. Of special joy to this administration is the addition of another chapter, Macomb County, making 22 links in Michigan.

Communication of the benefits of membership and certification has been aided by our representation on the MSMS Committee on Public Relations and the MSMS Task Force. We are most grateful for the opportunity to increase mutual understanding with the doctors in the Michigan State Medical Society.

Through the efforts of our Education Chairman, Genevieve Derr, CMA, the Baker Institute in Flint received approval of their medical assistant program by the AMA-AAMA Accreditation Board. This is the first such accredited institution in Michigan. AMA and AAMA have collaborated on the accreditation of medical assisting programs since July of 1969, when curriculum standards were approved by the AMA House of Delegates.

The AMA Council on Medical Education with the American Association of Medical Assistants have been recognized by the U.S. Commissioner of Education as an official agency to accredit educational programs for the medical assistant.

A committee of our Michigan medical assistants is presently working with the State of Michigan Department of Education on a project of rewriting the Manual of Performance Objectives for the Medical Office Assistant.

My sincere thanks to our doctor advisors, from whom advice is valued, and to the staff at MSMS . . . Warren Tryloff, Executive Director; Herb Auer, MSMS Director of Communications; and Jackie Van Deventer, MSMS Coordinator. In conclusion, with tremendous pride in our profession and in our organization, I thank you and urge your continuing support.

REPORTS OF THE COUNCIL

14. Remarks of The Council Chairman — Robert M. Leitch, MD

The Annual Report of The Council is in your Handbook and has been discussed at the Councilor Conferences. It is a brief summary of The Council's activities since the last meeting of the House and I will not review it here. I will just tell you today what has transpired since that report, including actions at The Council meeting this morning.

ACUPUNCTURE

As we have reported to you in *Michigan Medicine* and the minutes of The Council, we as the practicing physicians of Michigan are concerned about acupuncture and we have been attempting to develop a position paper. A fine report by Doctor Gascoigne containing several alternatives was distributed to component societies for their reaction as to what our future course of action should be. Responses from the components were reviewed by Secretary Johnson and reported to The Council this morning. Based upon them, his recommendations were adopted by The Council this morning as follows:

1. That The Council supports unequivocally the position taken by the State Medical Practice Board and the Osteopathic Board that acupuncture is the practice of medicine.
2. That the Chairman of The Council appoint a committee composed of appropriate, selected and knowledgeable physicians to maintain an ongoing evaluation of all developments in the field of acupuncture, reporting directly to The Council all phases of progress as they may occur.

Since this Council action is reported for information only, it will not be referred to any reference committee.

REPORT OF COMMISSION ON CONTINUING EDUCATION

The Commission on Continuing Education, chaired by Doctor Heideman, has been engaged in developing a proposed program for Michigan. You have received a copy of this report in your notebooks. The Council this morning approved the recommendation of the Comission contained in the report.

The Speaker will refer this Council action to Reference Committee F which is also considering the report of the Commission.

COMMISSION ON CONTINUING MEDICAL EDUCATION
Report to The Council, MSMS
March 13, 1974

The Commission on Continuing Medical Education met on August 15, October 3, and December 5, 1973 and on February 27, 1974. It has reviewed the work of the Committee on Post-graduate Education, of the Ad Hoc Committee on Continuing Medical Education, and the charge to the Commission by the 1972 House of Delegates. It has also attempted to define the nature of the program which would best meet the needs of physicians in Michigan, has studied the AMA Council on Medical Education requirements for designation as the accrediting body for programs within the state, and has reviewed a number of the programs of currently existing accrediting bodies and the certification programs of a number of the state medical societies. A tentative program has been formulated for Michigan.

The charge of the 1972 House of Delegates to the Commission on Continuing Medical Education is:

"(1) To develop a flexible series of minimal continuing medical education standards for physicians practicing in Michigan.

(2) That such standards be based on a broad approach requiring a set number of credits using facilities and approved programs of hospitals, medical schools, county, state and national societies and other current and developing methods of continuing medical education as determined by the permanent commission.

(3) That the Michigan State Medical Society establish basic principles of approval for all continuing medical education programs in the State of Michigan and also guidelines for reciprocity with accredited programs of other state, regional and national organizations."

It is the finding of the Commission that the only logical way of fulfilling these charges is the development of a program meeting the requirements of the AMA Council on Medical Education in that such a program would be based on a minimum set of standards, require 150 hours of continuing education over a three year period and allow acceptance of a wide variety of sites and formats, and provide a mechanism for reciprocity in that accreditation by the Council can be accepted at face value. Such programs have met standards comparable to ours to achieve accreditation and certification approval. The AMA guidelines to approval as an accrediting body are set forth in Exhibit I.

The goal of the program is to contribute to the continuing improvement of the health care of our population by steps designed to assure the maintenance of proficiency, the dissemination of new knowledge and of new skills as these become available, the remediation of identified weaknesses, and the provision of opportunities for development of additional skills by practitioners in accordance with their interests and perceived needs. Specific objectives for accomplishing these goals have not been defined as yet by the Commission.

The AMA program requires the completion of 150 hours of continuing education activity in a three year period providing for six categories of

study with some restriction on the amount of time to be claimed in any one of these. The program is in fact a minimal one with quite liberal provisions. The details are set forth in Exhibit II.

The accreditation program has been instituted by a number of states with considerable interest by the hospital staffs and success. In general, the pattern has been to finance the entire program by —

(1) A filing fee to accompany the request for review and a site visit.

(2) The payment of the costs and honorarium for the survey team by the hospital or its staff.

It is the finding of the Commission that the programs should be structured to meet a variety of needs, such as,

(1) General review programs

(2) Programs presenting new advances

(3) Programs permitting the practitioner to remedy felt or identified weaknesses in the care she or he provides

(4) Programs for developing new skills

The curricula within an institution should be constantly reviewed and so structured as to include all areas and aspects of medicine over a limited period of time. The preliminary program is described in Exhibit III.

Institution of this program will not require any net expenditure by MSMS, since any costs incurred would be reimbursed by the institutions who are certified to offer programs. When the certification is in full operation, it will require no more than a half-time clerk to do the necessary processing and paperwork.

It must be emphasized that this is a preliminary draft and is subject to further development and change by the Commission in consultation with staff of the Department of Continuing Education of the AMA Division of Medical Education.

RECOMMENDATION: That the proposed program of the Commission on Continuing Education be approved in principle and that the Commission be authorized to proceed in the directions outlined.

EXHIBIT I
FLOW SHEET

1. State medical society decides to plan and implement accreditation program for intrastate institutions.
2. State medical association prepares an *"Essentials,"* presurvey questionnaire, and team report form (based on AMA models or approved state models).
3. Liaison with Department of Continuing Medical Education at AMA is maintained to assure document preparation quality and completeness.
4. State medical association sends proposed accreditation plan to AMA (Department of Continuing Medical Education).
5. State Medical Association plan is presented to Advisory Committee on Continuing Medical Education.
6. Advisory Committee makes recommendation to Council on Medical Education re: State planning.
7. Council takes appropriate action re: The application of a state medical association accreditation plan.
8. If provisionally approved, state association implements plan doing several surveys during year of approval.
9. Advisory Committee member or other expert surveyor and AMA staff member observe one of early state surveys to provide assistance.
10. One Advisory Committee member and one AMA staff member are present during state accreditation committee meeting, hopefully during the same visit when a survey is observed. (See VII).
11. At the end of provisional year of approval, a survey team representing the Advisory Committee and staff, review state program and present the report on approved form to Advisory Committee for further action.
12. If a state medical association is fully accredited for its program of accreditation in continuing medical education, it will be for a period of approximately four years from the date of the accreditation action.

EXHIBIT II

Table 1.—Creditable Continuing Medical Education (CME) Activities, July 1, 1970—June 30, 1973

	CREDIT HOUR LIMIT
Category 1— CME Activities With Accredited Sponsorship	No Limit
Category 2— CME Activities With Nonaccredited Sponsorship	45 hours
Category 3— Medical Teaching	45 hours
Category 4— Books, Papers, Publications and Exhibits	40 hours
Category 5— Nonsupervised Individual CME Activities — Subcategories*	45 hours
Category 6— Other Meritorious Learning Experiences	45 hours

A total of 150 credit hours is needed to qualify for the 1973 Award. At least 60 credit hours must be in Category 1.

*A—Self-Learning
B—Consultation
C—Patient Care Review
D—Self-Assessment
E—Specialty Board Preparation

22 Credit hour limit for **each** subcategory not to exceed 45 credit hours total for category 5.

EXHIBIT III
PRELIMINARY PROGRAM

(1) Help to local areas in determining their own needs.

(2) Assistance in planning programs (in sufficient time so that the program can be reviewed by the Commission before it is announced and final arrangements are made.)

(3) Help groups plan to set forth objectives for all programs and efforts and to follow through with an evaluation.

(4) Try to determine if the program resulted in changing the behavioral performance of those who attended.

(5) Provide groups with certification cards — this will prove attendance and give an opportunity for getting an evaluation of the program from the attendees.

(6) Provide on-site visits.

(7) Visit hospitals where it seems progress is unsatisfactory.

(8) Regionalize the state and have representation from each region on the Committee.

(9) Provide a suitable award.

REFERENCE COMMITTEE F, James C. Danforth, MD, Chairman, recommended that the proposed program of the MSMS Commission on Continuing Education be approved in principle and that the Commission be authorized to proceed forthwith, in conjunction with AMA Standards and Guidelines, and that a report on progress of the program be submitted at the next meeting of the MSMS House of Delegates.

THE HOUSE adopted the report of the Reference Committee.

REPORT OF TASK FORCE ON GRADUATE MEDICAL EDUCATION RE: "SHOTS"

This report regarding a Statewide House Officers Training System has been discussed on three different occasions by The Council and this morning The Council adopted recommendations 1) That MSMS through its Council continue to participate in the evaluation of SHOTS; and 2) That The Council lend its support to the proposed study.

The Speaker will refer this Council action to Reference Committee C which is considering the Task Force report.

Statewide House Officer Training System—A Proposal

A. OBJECTIVES OF THE SYSTEM

1. To train high quality physicians for medical care delivery in the State of Michigan in accordance with defined physician manpower needs of the state.

2. To improve the quality of the training available to house officers in Michigan hospitals and other health care institutions.

3. To improve the quality of health care delivery in Michigan by attracting more and better house officers to the state.

4. To establish an integrating mechanism for the system of house officer training in the State of Michigan.

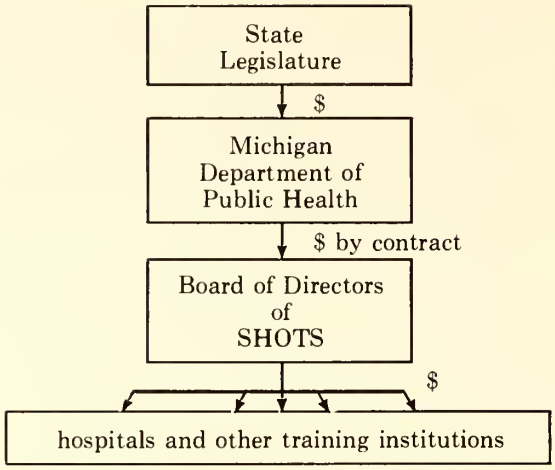
5. To supplement the present inadequate system of financing house officer training programs.

B. SUMMARY DESCRIPTION OF PROPOSED STATEWIDE HOUSE OFFICER TRAINING SYSTEM

This proposal suggests the creation of a Statewide House Officer Training System (SHOTS) in the State of Michigan to fund and coordinate house officer training in the various specialties and subspecialties of allopathic and osteopathic medicine. A nonprofit corporation would be created which would receive funds from state government to improve all forms of house officer training from the first postgraduate year to entry into practice (This includes the traditional phases of internship, residency, and clinical fellowship training; it would not include fellowships designed primarily for research training). A central governance structure would be created with representation from community hospitals, educational institutions, third party insurance carriers, house officers, and various professional groups. SHOTS would set admission standards for trainees, approve training program curricula, allocate funds, periodically evaluate both trainees and training programs, and certify trainees to the appropriate specialty and subspecialty boards. Most importantly, SHOTS would gather reliable data on the physician manpower needs of the State of Michigan and would use this data as a major determinant of the types and numbers of house officer training programs conducted. Participation in SHOTS would be on an institutional rather than individual specialty basis and would be voluntary rather than compulsory.

C. RELATIONSHIP TO STATE GOVERNMENT

It is proposed that a private non-profit corporation be created to operate SHOTS. The non-profit corporation would request state funds to finance the house officer training system. These funds would be provided by the state legislature as an annual line item appropriation to the Michigan Department of Public Health, which would, in turn contract with the non-profit corporation to operate SHOTS. The Board of Directors of SHOTS would thus be accountable to state government through the Michigan Department of Public Health.



The Board of Directors of SHOTS would also establish liaison with other agencies of state government which are concerned with the education and training of health professionals and with health care delivery. These include the Office of Health and Medical Affairs, the state Office of Comprehensive Health Planning, and the State Health Planning Advisory Council. Such liaison will be of particular importance to the development of a mechanism for determining Michigan's physician manpower needs.

D. GOVERNANCE

1. BOARD OF DIRECTORS: The Board of Directors would be the policy-making body of SHOTS and would be responsible for operation and management of the statewide system. Its specific responsibilities would include:

a. hire the Executive Director;

b. elect the Executive Committee from amongst its membership;

c. appoint the Professional Advisory Groups based upon nominations from participating health care institutions;

d. obtain reliable data on physician manpower needs of the State of Michigan;

e. establish standards for institutional participation in SHOTS and approve participating institutions in accordance with those standards;

f. review the recommendations of the Professional Advisory Groups regarding the curricula of the various training programs conducted in participating institutions and specify minimal cirriculum standards and optimal curriculum goals for these programs. The standards set by the Board must, at a minimum, meet the standards required by the various national accrediting bodies in allopathic and osteopathic medicine;

g. set minimal admission standards for trainees in participating institutions;

h. set minimum and maximum stipend levels for trainees in participating institutions;

i. develop and maintain liaison with other health care and health education groups in Michigan and the United States in areas of mutual interest;

j. develop and operate a uniform evaluation system for:

1) individual trainees;

2) participating training programs (this evaluation mechanism would be based on the peer review principle);

k. certify trainees to the appropriate national specialty and subspecialty boards (such certification would supplement but not replace certification by the individual training institution);

l. establish a budget, request appropriations from state government and other sources, allocate funds in accordance with the budget, and maintain fiscal responsibility for the system.

Membership on the Board of Directors would be as follows:

a. 4 physician educators from participating hospitals, appointed by the Michigan Association for Medical Education;

b. a representative from each of the four medical schools in Michigan appointed by the dean of the respective medical school;

c. 4 representatives of third party insurance groups in Michigan — one from Michigan Blue Cross, one from Michigan Blue Shield, one Michigan representative of the Health Insurance Council, and a representative from the Michigan Department of Social Services. These individuals would be appointed by their respective groups and would provide consumer input to the Board;

d. 3 house officers from participating hospitals. The house officer representatives would be elected by the other members of the Board of Directors from among a slate of candidates nominated by participating hospitals. At least one of the 3 house officers should be a Doctor of Osteopathy;

e. 1 representative appointed by the Michigan State Medical Society;

f. 1 representative appointed by the Michigan Association of Osteopathic Physicians and Surgeons;

g. 1 representative appointed by the Michigan Hospital Association;

h. 1 representative appointed by the Michigan Osteopathic Hospital Association;

i. the Executive Director of SHOTS who would serve ex-officio without vote.

With the exception of the representatives of the 4 medical schools, who would serve at the pleasure of their respective deans, the members of the Board of Directors would serve staggered 3 year terms with 5 new members appointed each year. The term of each house officer on the Board would

end when his/her house officer status terminated or at the end of 3 years, whichever was sooner.

The Board of Directors would establish its own Bylaws and elect its own officers.

2. EXECUTIVE COMMITTEE: The Executive Committee of SHOTS would be elected by the Board of Directors from amongst its membership. It would consist of 7 elected members (5 physicians and 2 non-physicians, including at least 3 non-University-based physician-educator, 1 medical school Dean or his designate, and 1 Doctor of Osteopathy) plus the Executive Director of SHOTS who would serve ex-officio without vote. Members of the Executive Committee would serve staggered three year terms. The Executive Committee would act for the Board of Directors between the regular and special meetings of the latter. It would make recommendations to the Board of Directors regarding appointment of the Executive Director and members of the Professional Advisory Groups. The Professional Advisory Groups would report to the Board of Directors through the Executive Committee.

3. EXECUTIVE DIRECTOR: The Executive Director of SHOTS would be appointed by the Board of Directors and would hold a full-time paid position. He/she would be a physician. The Executive Director would be responsible to the Board of Directors for administering SHOTS in accordance with the policies determined by the Board. He/she would serve ex-officio without vote on both the Board of Directors and the Executive Committee. The Executive Director would hire a staff as needed to conduct the various functions assigned by the Board to his/her office.

4. PROFESSIONAL ADVISORY GROUPS: There would be a Professional Advisory Group (PAG) for each specialty or subspecialty discipline in which SHOTS had one or more participating training programs. At a minimum, each PAG would include 1 physician representative from each participating training program in the discipline involved. Representatives from other disciplines could be added at the discretion of the Board of Directors. Appointment of PAG members would be the responsibility of the Board of Directors following nomination by participating institutions. Each PAG would report to the Board of Directors through the Executive Committee of SHOTS. The responsibilities of each PAG would include:

a. recommend to the Board of Directors minimal standards and optimal goals for the curriculum of participating training programs in the specialty or subspecialty discipline involved. These curriculum standards would, at a minimum, meet the standards set by the appropriate national accrediting bodies in allopathic and osteopathic medicine (it is proposed that each PAG include representatives from allopathic and osteopathic training programs; however, in proposing curriculum standards a PAG must take into consideration the different requirements of national accrediting groups in allopathic and osteopathic medicine. For this reason, a dual set of curriculum standards — one for osteopathic medicine and one for allopathic medicine — would be required in most cases);

b. recommend to the Board of Directors appropriate admission standards for trainees in the discipline involved;

c. recommend to the Board of Directors an appropriate mechanism for evaluating the performance of trainees in the discipline involved;

d. recommend to the Board of Directors an appropriate mechanism for periodic evaluation of individual training programs. This evaluation would be based upon the principle of peer review;

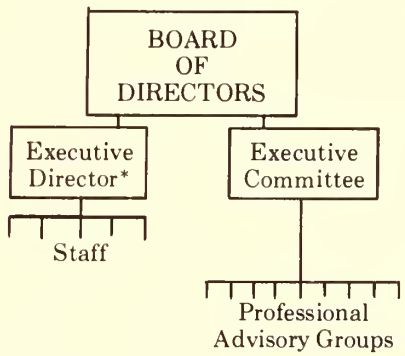
e. advise the Board of Directors regarding physician manpower needs in the specialty or subspecialty area involved;

f. establish liaison with appropriate professional groups in the specialty or subspecialty area involved;

g. be available, upon request, to provide consultation to participating training programs in the discipline involved;

h. make recommendations to the Board of Directors regarding other matters which might have an impact upon the successful operation of training programs in the discipline involved.

5. ORGANIZATIONAL DIAGRAM OF SHOTS



*ex-officio without vote on Board of Directors and Executive Committee

E. CRITERIA FOR PARTICIPATION IN SHOTS

Participation in SHOTS would be voluntary and would be on an institutional rather than an individual program basis. The Board of Directors would establish criteria for institutional participation in SHOTS, receive applications from hospitals and other institutions running house officer training programs, and determine which applicants met the established criteria.

All of the house officer training programs conducted by an applicant institution would require approval by the Board of Directors to make the in-

stitution eligible for participation. If an existing program within a hospital was not approved initially, or was subsequently disapproved by the Board of Directors, the hospital would have the option of discontinuing that program, improving it sufficiently to regain approval, or withdrawing as an institution from participation in SHOTS.

A participating institution could not conduct a program not approved by the Board of Directors and still participate in SHOTS. The standards set by the Board of Directors for house officer programs operated within the system must, at a minimum, meet the standards of the appropriate national accrediting body in allopathic or osteopathic medicine. It is recognized that the latter recommendation would result in separate criteria for approval of allopathic and osteopathic house officer programs in most cases.

F. ADMISSION PROCESS FOR HOUSE OFFICERS

Minimal standards criteria for the admission of trainees into house officer programs conducted by an institution participating in SHOTS would be determined by the Board of Directors with advice from the Professional Advisory Groups. The selection of individual trainees from amongst the pool of candidates who met the standard criteria would remain the prerogative of the individual training programs. The admission criteria adopted by the Board of Directors would, at a minimum, meet the requirements of national accrediting groups in allopathic or osteopathic medicine.

G. EVALUATION PROCESS

The Board of Directors would establish a uniform system to evaluate both the house officers enrolled in participating training programs and the training programs themselves. The evaluation policies adopted by the Board of Directors would be administered by the Executive Director of SHOTS. The Uniform evaluation system for **trainees** would perform the following functions:

1. periodic evaluation of each trainee during the course of his training program with feedback both to the program and to the trainee. This evaluation would be based upon the development of criteria for acceptable performance at each successive phase of the program. The professional Advisory Group in the discipline involved would assist in the development of these criteria and in the construction of appropriate evaluation instruments. A periodic evaluation program of this type would permit program directors to compare their trainees with those in other programs throughout the state. It would also facilitate the institution of remedial measures **during** a house officer's training rather than in the post-training period when such measures would be difficult to accomplish;

2. terminal evaluation of the trainee for the purpose of certifying him/her to the appropriate specialty of subspecialty board. Certification by SHOTS would supplement but not replace certification by the hospital conducting the training program.

The Board of Directors might wish to contract with an outside agency which possessed evaluation expertise to assist in the design and operation of the trainee evaluation program.

The Board of Directors would, with the advice and assistance of the Professional Advisory Groups, establish policies for the periodic evaluation of individual training programs. These policies would be based upon the principle of peer review and would be administered by the Executive Director.

The activities of SHOTS in the field of trainee and program evaluation would supplement but in no way encroach upon the activities of the national accrediting bodies in allopathic and osteopathic medicine.

H. RELATIONSHIP OF ALLOPATHIC AND OSTEOPATHIC MEDICAL PROFESSIONS

It is proposed that both allopathic and osteopathic hospitals which conduct house officer training programs be eligible for participation in SHOTS. As previously noted, both professions would be represented on the Board of Directors, the Executive Committee, and on a single set of Professional Advisory Groups.

Joint participation in SHOTS would promote cooperation between allopathic and osteopathic medicine, facilitate an interchange of ideas, and result in better training for both the M.D. and D.O. house officer. It must be recognized, however, that the two professions have separate identities and that each has its own set of house officer training requirements and national accrediting bodies. For this reason, it would be necessary in most instances for the Professional Advisory Groups and Board of Directors to develop two distinct sets of requirements related to admission standards, curriculum, and evaluation. Both the osteopathic and the allopathic requirements would, at a minimum, meet the standards set by the national accrediting bodies in each profession.

I. FINANCING

1. SOURCE OF FUNDS: An adequate supply of well-trained physicians is an essential feature of any health care delivery system. It is therefore in the best interests of the people of Michigan to support programs designed to train more and better physicians to practice in the state. Since the production of a qualified physician requires in all cases some form of house officer training beyond medical school, it is appropriate that the philosophy which provides for public support of undergraduate medical education be extended to include internships, residencies, and clinical fellowships.

2. ALLOCATION OF FUNDS: There are three categories to which funds received from state government would be allocated:

a. capitation payments to participating institutions

Each training institution which qualified for participation in the statewide system would

receive an annual capitation payment from SHOTS to assist it in conducting its house officer training programs. Capitation payments would be based upon the following formula:

(1) an annual payment of $2,000 for each internship, residency, and clinical fellowship position for which an institution was approved by the Board of Directors of SHOTS. It is proposed that capitation payments be made only for those fellowships which are required for certification by specialty and/or subspecialty boards or which lead to general recognition as a specialist or subspecialist in some field of clinical practice; fellowships designed primarily for research training would not be included. The Board of Directors would determine the number and types of house officer positions for which an institution was approved by the statewide system. This number might be less than the number of house officer positions for which an institution was approved by national accrediting bodies but in no case would be more. The Board of Directors would review periodically the number of positions in each specialty for which approval was granted by SHOTS and alter this number based upon need for physicians and each institution's actual experience in filling its house officer slots. In addition, the Board of Directors would have the option of altering the basic capitation payment from specialty to specialty.

(2) an additional annual payment of $1,000 for each approved internship, residency, or clinical fellowship position which was filled by a trainee who met the admissions requirements determined by SHOTS.

Capitation payments to participating institutions would be used as a supplement to improve house officer training programs in Michigan and would not replace existing support from third parties and other sources. To ensure that this was indeed the case such payments would be dependent upon a **maintenance of effort** from existing sources of financial support.

The Board of Directors of SHOTS would have the option of specifying the ways in which capitation payments could be used by participating institutions. Examples of costs which might be met wholly or in part by capitation payments include the following salaries of training program directors and teaching staff; salaries or administrative personnel assigned to educational programs; house officer stipends; educational space and equipment; library support.

b. **funds for program development**

It is proposed that funds be made available to the Board of Directors to be used for development of new and innovative house officer training programs in Michigan. Such funds might, for example, be used to initiate additional training programs in primary care disciplines or in areas of the state which are not now conducting house officer training and in which there is a shortage of physicians. An initial annual appropriation of $100,000 would be allocated for this purpose.

c. **administrative and operational expenses**

Funds would be required to operate the governance and administrative structure of SHOTS. Specific items in this category would include operation of the Executive Director's office, establishment of a uniform evaluation capability, and the development of data on physician manpower needs of the state. It is estimated that expenses in this category would approximate $400,000 per year.

3. EXAMPLES

a. **sample budget for first year of full operation of SHOTS**

Capitation payment to participating institutions (assuming 2500 house officer positions in Michigan are **approved and filled**)	$7,500,000
Program development	100,000
Administrative and operational expenses	400,000
Total	$8,000,000

b. **sample payments to individual hospitals**

(1) Hospital A: Approved for 20 house officer positions by Board of Directors and fills all 20

$2,000 per approved position × 20	= $40,000
$1,000 per filled approved position × 20	= 20,000
Total	$60,000

(2) Hospital B: approved for 20 house officer positions by Board of Directors and fills 11 of these

$2,000 per approved position × 20	= $40,000
$1,000 per filled approved position × 11	= 11,000
Total	$51,000

REFERENCE COMMITTEE C, George Porretta, MD, Chairman, recommended the following regarding the proposed Statewide House Officers Training System (SHOTS): 1) that MSMS through its Council continue to participate in the evaluation of SHOTS, and 2) that The Council lend its support to the proposed study.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE TO STUDY PROPOSAL FOR THIRD PARTY PARTICIPATING AGREEMENT

As we announced to the Delegates and Alternates at Councilor Conferences, The Council has been studying the feasibility of unifying the profession in relation to third party carriers. At a meeting last evening a Council subcommittee developed the following recommendation, which was subsequently adopted by The Council this morning: "That The Council request the House of

Delegates for authority to develop participation agreements with third-party carriers. These agreements will be offered to the individual members of MSMS and the services of the Michigan State Medical Society will be provided as their negotiating agent." The minutes of the subcommittee's meeting are available for your review and these minutes, as adopted by The Council, will be referred to Reference Committee E, which is also considering Res. 36. (See Res. 36 for House action.)

The subcommittee's minutes follow:

REPORT TO THE COUNCIL
MAY 5, 1974

MEETING OF THE AD HOC COMMITTEE TO STUDY DOCTOR MCCALL'S PROPOSAL RE MSMS RELATIONSHIPS WITH THIRD PARTIES

RECOMMENDATION: That The Council request the House of Delegates for authority to develop participation agreements with third party carriers. These agreements will be offered to the individual members of MSMS and the services of the Michigan State Medical Society will be provided as their negotiating agent.

The meeting was called to order at Boyne Mountain at 7:45 p.m., May 4, 1974, by Chairman Lahti.

Present were:
Paul T. Lahti, MD, Chairman
Louis E. Heideman, MD
Leland E. Holly, II, MD
Adam C. McClay, MD
Sydney Scher, MD

Advisors present:
Marion G. McCall, Jr., MD
A. Stewart Kerr

Also present:
Richard Allen, MD — delegate — by invitation
Brock Brush, MD
James Fryfogle, MD
Robert M. Leitch, MD, ex-officio

At the direction of the Chairman, the following were considered by reading and discussion:

1. "A Proposal for a Rational Approach of MSMS to Third Party Programs" (MSMS mailing)
2. Resolution #36 of the current House of Delegates
3. Committee charge from Council motion which was: "This matter be approved in concept only and referred to committee for subsequent report to The Council."
4. The Chairman interpreted the words "This matter . . ." from The Council action to be the three gray pages entitled, "A Proposal for Council Consideration March 13, 1974, Marion G. McCall, Jr., MD."

Doctor McCall discussed the importance of the concept in this request for an alteration in MSMS policy. He urged that The Council recommend a specific proposal to the House of Delegates.

General discussion with great participation by all elicited much information. Certain pivotal points were discussed more than others as the Committee reviewed "this matter" paragraph-by-paragraph; namely

1. The concept of a master third party contract and defense of individual members when the contract was broached by third parties.
2. What is a service benefit? e.g.
   a) Limited service contract?
   b) Full service contract?
   c) Co-pay contract?
   d) Benefits spelled out as services in a pre-defined "benefit package"?
3. Price fixing — especially percentile limits.
4. Renewability of contracts.
5. Concept of "everything is negotiable."
6. Concept of "clearly defined contractual relationships."
7. 3rd party assist in paying professional liability insurance.

A motion was made that the Committee recommend to The Council the seven concepts of Doctor McCall's proposal rewritten by the Chairman particularly in a manner to remove the stigma of "service benefits." Made by Holly, seconded by Heideman, the motion was put and failed.

The second motion was that this Committee recommend that The Council request the House of Delegates for authority to develop participation agreements with third party carriers. These agreements will be offered to the medical physicians of Michigan and the services of the Michigan State Medical Society will be provided as their negotiating agent. Made by Heideman and seconded by several, the motion was put and passed.

The meeting was adjourned at 10:25 p.m.

The Chairman wishes to thank all the Committee members, officers, advisors, and guests in attendance for a fine productive effort, and special thanks to Doctor Holly for his contribution as acting secretary.

The recommendation was adopted by The Council, Sunday, May 5, 1974.

PSRO

As mandated by the House of Delegates we have been proceeding on several fronts to implement the 1973 resolution regarding PSRO. We have a report from the Committee on Peer Review Systems, Chaired by Daniel J. Fall, MD, and Doctor Kenneth Ray, a member of the Committee, will read the report at this time.

DOCTOR RAY:

The Committee has had a number of charges

from the House of Delegates including the obligation to monitor the activity of the Department of Health, Education and Welfare in its promulgation of regulations relating to the PSRO law, as well as the review and evaluation of alternate peer review systems. As most members of the House of Delegates are aware, the Committee spent a good deal of time and effort in trying to guide the Department of HEW into a rational area designation for PSROs in the State of Michigan. This resulted in several trips to Washington to discuss the rationale of the MSMS proposed area designations with officials in the Office of Professional Standards Review as well as testimony at the formal hearing held by HEW, Region V, in Lansing last August. Our recommended area designations were based upon a survey of component medical societies to determine current patient referral patterns and current physician-communication channels. We applied this information to the guidelines published by the Office of Professional Standards Review and were able to draw up a proposed area designation map for the State of Michigan. Because of the fiscal limitations on the number of PSROs that could be funded, the Committee's recommendations were not totally acceptable to HEW. After lengthy discussions, however, we were able to achieve an acceptable compromise and the final map was published in Medigram.

There was initially a major philosophical difference as to whether or not a statewide support center would be allowable. The feeling of the governmental officials was that this was not specifically allowed in the law and therefore would not be permitted. It was the view of our Committee that a statewide support center could offer considerable financial advantages to the government by providing administrative and technical services to the individual PSRO on an efficient basis. There was also a very strong feeling such a statewide support organization would help to maintain the State Medical Society's position as the spokesman for physicians. On several occasions during the last two years, committee members as well as representatives of national medical organizations pointed out the fiscal advantages of such a support organization to the officials in HEW, and I am pleased to report that the recently published PSRO regulations provide for statewide support centers which are independent of the state advisory PSRO council. It is our opinion that the creation of such a center by MSMS would be an extremely important mechanism for maintaining a unified voice in future negotiations with the Federal Bureaucracy.

The Committee carefully examined the system for peer review developed by the Ohio State Medical Society-sponsored Medical Advances Institute. Committee members visited Columbus, Ohio, to review the operation of the pilot program and we also had the opportunity to participate in a demonstration of the program at a meeting in East Lansing with MAI officials. It is fair to state that the Committee as a whole was favorably impressed with the overall functioning of the program even though many details require further refinements. It is extremely important to point out that this pilot program took approximately 3 years to get to this stage even with the assistance of computer expertise from Ohio State University and the 18,000 physician man-hours that went into developing the program. It does not seem feasible for the Michigan State Medical Society to undertake the initiation of a program of this magnitude since we have definite time limitations proposed by HEW. We doubt from the financial point of view that the physicians of the state could or would back such a massive effort. We realized that if it were to be feasible for us to initiate a massive formalized system of peer review such as the Ohio Plan it would be necessary for us to borrow or contract with organizations already operational for their expertise in computer support. This is possible through the Ohio Medical Advances Institute at the cost of approximately $10 per chart review. While this is an extremely efficient figure for review of one chart, if one extrapolates this for the entire state, a large amount of money would be needed to accomplish this and outside funding would be essential. It must not be forgotten that this is still a pilot program which may or may not satisfy the requirements of the PSRO law.

The Genesee County Foundation was also examined by the Committee, and Eric VanDuyne, MD, that organization's president, was kind enough to spend many hours going over its plan with us. While it is true that this plan could serve as a model for the entire state or for individual PSROs, it is also true that the foundation has not had sufficient experience with the implementation of peer review to make any judgment about the effectiveness or acceptability of this program.

While it is appropriate for our Committee to monitor and influence the development of PSRO regulations, we found it difficult to attempt the other huge task of seeking repeal of the PSRO law. The unanimous opinion of the Committee has been that there are many faults with this law and we would be much happier if it were repealed. It naturally follows that the Committee has been interested in and has sought information about the possibility of repeal of the entire law, and it is our feeling that while this is not impossible, it is rather unlikely. Nevertheless, we feel that there is much that can be done on a local and state level to educate congressmen about the need for revision and modification and we have attempted to do this by meeting with the administrative assistants of our congressmen in Washington. The AMA and the other national medical organizations should be encouraged to continue their efforts to repeal or effectively amend the PSRO law.

At this point in time, the Michigan State Medical Society should endorse the concept of a statewide support center and should actively pursue this concept so that MSMS will remain a potent force in PSRO implementation. This is not to say that this endorsement of a statewide support organization means that we believe that the PSRO law is good or proper. It does mean that we see our obligation to retain as much control over PSRO as

possible and to equip local physician groups with the necessary resources to plan and negotiate acceptable contracts.

The Michigan State Medical Society has to make some financial as well as philosophical commitment to continuing the activities of the peer review committee. It should be apparent that the activities of this Committee have required a major time commitment on the part of the committee members and also on the part of the MSMS staff. Regulations are proliferating in an exponential fashion and it is becoming increasingly apparent to us that additional administrative staff will be needed simply to keep us with what is happening. As chairman of the Committee I see our task increasing in magnitude and wonder if it should be divided and assigned to two committees. One could be charged with monitoring and informing the membership of the regulations and doing all in its power to assist local physician groups in their dealings with HEW re PSRO. The second committee could be charged with investigating alternate systems and determining their acceptability.

In conclusion, we see a continued obligation on the part of MSMS to keep its members informed on PSRO developments and to offer assistance to county medical societies and to local PSROs as they emerge.

Because of the April 30 deadline for the submission of an application for a planning award to create an MSMS statewide support center for regional PSROs, MSMS has filed such an application and it is now in the hands of HEW.

Treasurer's Report

A report on our financial condition is included in the Annual Report of The Council. I will now call on our Treasurer, John Ylvisaker, MD, of Pontiac, for some additional informative comments.

DOCTOR YLVISAKER:

My remarks today will involve four basic areas of interest:

1. The financial condition of MSMS
2. The status of our operating and reserve funds
3. The need for dues increase based on financial projections
4. The use of our reserve funds for support of proposed projects

1. I am glad to assure you that your state society is financially sound, solvent, and operating responsibly within its budget. The 1973 fiscal year was closed out with a positive balance. The budget for 1974 is just over a million dollars, is balanced, and income should provide a small cushion. Year-end audit results have been reviewed by The Council Finance Committee under its Chairman, Doctor Ernie Griffin and by the House Ways and Means Committee under Doctor David Siegel.

2. As you recall, we have three funds for which specific guidelines have been outlined: the Operation Fund, the Capital Reserve Fund, and the Creative Reserve Fund. The Operation Fund is in fixed dollar instruments and is benefitting greatly from the high interest yields presently available. The conservatively invested Capital Reserve Fund at year-end reflected an approximate 8 percent decline in market value. The more aggressively invested Creative Reserve Fund has more closely reflected the Dow Averages with a decline of 16 percent. Total market value of these two funds at 11/30/73 is 4 percent below the value of the originally invested funds. The detail of all of these funds is recorded in the audit.

3. Let us turn now to some consideration of the near future. A proposal for a necessary expansion of the MSMS staff has been approved by The Council and is currently scheduled for consideration by the House. The basic cost is $127,500. Of this, $23,000 is designated for an innovative research and development position related to the new world of PSRO. A few quick facts are relevant re income, expenses, and dues:
   1. Historically, income has increased year-by-year at the rate of 1 percent not considering changes in dues.
   2. Expenses are now rising at a 4 percent rate.
   3. Dues increases over the past 20 years have occurred regularly at 5 year intervals.
   4. The magnitude of increase has averaged 30 percent per each 5 year period. Careful review by the MSMS staff, by the Finance Committee, by myself as Treasurer, and by the Ways and Means Committee confirms the need for additional revenue for 1975. The amount of the increase is subject to the recommendation of the Ways and Means Committee and to your decision. Investigation indicates that $20 to $25 additional revenue per member will be necessary to provide adequate funds for the next 2 to 4 years.

4. In the late 1960s, we established the two reserve funds with the intent that each would be available to serve specific purposes. The Creative Reserve Fund is basically an R & D fund and has not been called into use to date. I am pleased that David Siegel, MD, with the Ways and Means Committee has identified the proposed peer review position as an R & D activity appropriate to the purpose of the Creative Reserve Fund. The Board of Managers has met and unanimously supported this recommendation with the mutual understanding that the obligation should be transferred for other appropriate funding whenever the position becomes an accepted part of the PSRO system or of MSMS operations.

In the same context, I would like to call to your attention that the Capital Reserve Fund is comfortably absorbing a major expense of recarpeting the Headquarters building. In addition, a study has now been authorized to develop site planning for a new office structure which, if eventually approved, will fall within the capacity of our Capital Reserve Fund as a normal obligation. I am pleased to report that these funds have assumed their proper role in the operation and planning of our Society.

Thank you.

Liaison with Blue Shield

Last year it was reported to the House that efforts were being made to improve liaison with Blue Shield within some basic guidelines. Pursuant to this, we have had meetings with the highest officers of MSMS and Blue Shield with some fruitful dialogue. In addition, we have embarked in preliminary discussions between the MD members of Blue Shield Board and MSMS for mutual input at this level.

Further, there has been some staff to staff communication about mutual problems and the feasibility of development of a liaison committee along the general lines of the Medicaid Liaison Committee.

Discontinuance of Phase IV Controls

One of the most important efforts of The Council has been to prevent the extension of the Phase IV price controls on physicians which was sought by the Cost of Living Council and some members of Congress. As you know, on April 30 the Economic Stabilization Act expired, ending wage and price controls on health services and several other segments of the economy.

The Council and many individual doctors (in response to appeals in *Medigram*) wrote their Congressmen and members of the Senate Banking Committee advocating an end to the controls.

The medical profession showed its ability during the 2½ year period of controls to conform to the federal guidelines.

Now that the controls no longer exist, AMA and MSMS are asking physicians to act in a judicious manner as responsible citizens. As members of the fastest growing segment of our economy, the impact of our decisions is widely felt. Arbitrary and unwarranted changes will draw immediate attention to the medical community, which currently is on the brink of further controls through possible national health insurance proposals.

The Council urges MSMS members to be sure that any fee adjustments are responsible and judicious. We would hope that each member of the House of Delegates would convey this important message to his constituents.

Miscellaneous Items

Now just a couple of items of interest:

We are pleased to report that the MSMS accounting and dues billing staff was able to offer dues collection services to component societies this year. Thirty-five counties have availed themselves of this service. It provides a real reduction in work for the component society secretaries and hastens receipt of dues income for all parties.

MSMS is studying methods of mechanizing its bookkeeping systems with the possible use of a computer which also would handle all address changes and labels for MSMS, the Auxiliary, the Medical Assistants and specialty societies for which we perform management services.

Concluding Remarks

As Chairman of The Council, I would like to commend to you the dedicated work of Vice-Chairman Robert C. Prophater, MD, and the Chairmen of The Council's three standing committees: Ernest P. Griffin, Jr., MD, Chairman of the Finance Committee; Ralph R. Cooper, MD, Chairman of Committee on Scientific and Educational Affairs, and Louis R. Zako, MD, Chairman of the Legislative Policy Committee. In addition, each member of The Council has worked long and hard on Council activities. There have been many meetings of some length and, in addition, many members of The Council serve on other MSMS committees. Each member of the many committees of MSMS also deserve your commendation for their dedicated service. Your Council in the coming year will attempt to carry out your wishes and direction to the best of its ability. Thank you.

15. Report of Council Activities

The Council has met four times since the last meeting of the House in October. Each delegate has received copies of the minutes of those meetings. The next meeting will be held Sunday, May 5, immediately preceding the House of Delegates meeting. Actions taken then will be reported by the Chairman in his remarks to the House that same day.

Some major concerns of The Council have been: revision of the Medical Practice Act; developments in national health insurance, solutions to professional liability problems; liaison with Blue Shield; peer review and PSRO developments health maintenance organizations, generic prescribing of drugs; Phase Four controls on health providers, gasoline for physicians' automobiles, liaison with Medicaid officials; work of MSMS Commission on Continuing Medical Education; and funding of graduate education in Michigan. Comments will be made on some of these items in this report. The last three items will be subjects of special reports to the House of Delegates.

* * *

Early in the period covered by this report The Council adopted several objectives for 1974. We will review our achievements at the mid-year Council meeting this August and again at year-end.

Here are the six objectives (by title only):

1. Peer Review Systems
2. Increase Membership (Recruitment and Retention)
3. Seek Relief from Malpractice Situation
4. Strengthen Influence with State and Federal Legislators and Agencies.
5. Improve Methods of Providing Leadership and Information to General Membership and Component Societies.
6. Strengthen Unified Position of Medical Profession Toward Health Proposals and Practices.

* * *

The Council comments on the following major areas of interest:

REPORT OF COMMISSION ON CONTINUING MEDICAL EDUCATION

The report of the Commission will be considered by The Council on May 5 and the Chairman will report any recommendation in his remarks to the House.

STATE HOUSE OFFICER TRAINING SYSTEM — STATE FUNDING FOR GRADUATE EDUCATION

Following the recommendations of the delegates last fall, The Council created an Ad Hoc Committee to Study the Funding of Graduate Education. The Committee made two reports to The Council. Action on the most recent report was postponed until May 5 and will be reported to the House in the Chairman's remarks.

TASK FORCE ON REGIONALIZATION OF HEALTH SERVICES

This group, chaired by Doctor John Coury, developed a response to the Governor's challenge to the House last fall. Copies of that response have been sent to the Delegates for information. The Task Force did a fine job and the Governor has praised the Michigan State Medical Society for its assistance.

LIAISON WITH BLUE SHIELD

As reported last fall, we have developed guidelines for relating to Blue Shield within restrictions set by the House. In March we had a meeting with the Blue Shield officers. We have invited MD members of the Blue Shield Board to organize themselves and a meeting with this group will be held in mid-May.

In addition, the membership has been surveyed to provide documentation for problems encountered with Blue Cross and Blue Shield. Responses to this survey will aid The Council in determining the scope and dimensions of problems practicing physicians are having with third parties. Also all member complaints have been brought to the attention of Blue Shield at a recent meeting between Blue Shield officers and the corporate body.

REPORT ON PROFESSIONAL STANDARDS REVIEW ORGANIZATION

Needless to say, this has been one of the major areas of concern this year, and a member of the MSMS Committee on Peer Review Systems, Doctor Kenneth Ray of Detroit, will report directly to you on this matter on May 5. However, a brief report of current information on the subject follows:

The final PSRO area designations were published in the Federal Register Monday, March 18. Michigan now has ten areas, identical to the MSMS recommendations reflecting the desires of component medical societies.

MSMS has contacted Washington re proposal requests for 1) planning contracts to develop area PSROs and statewide PSRO support center contracts. Proposals for both type contracts must be received by the HEW contract officer no later than 4 p.m., on Tuesday, April 30, 1974, although there is a probability that this deadline will be extended.

The Wayne County Medical Society Council has authorized its Committee on PSRO Programs to make application for a planning grant, and the Genesee Medical Corporation is proceeding to make application to qualify as a conditionally designated PSRO to serve Genesee, Lapeer and Shiawassee Counties.

The MSMS Council has authorized appropriate MSMS committees and task forces to assist component societies in establishing peer review mechanisms and to seek HEW designation of MSMS as a Statewide Professional Standards Review Organization Support Center so that guidelines for the establishment and operation of PSRO can be communicated and explained to component societies, if they so request. The MSMS proposal will be submitted prior to the April 30 deadline.

UNIFICATION OF MEMBERSHIP IN RESPONDING TO HEALTH INSURANCE PROBLEMS AND CHALLENGES

The Council adopted a principle that it might better serve as an advocate for MSMS members if the membership could be unified behind a participating agreement developed by MSMS and adopted by third-party payers.

The agreement would detail under what terms MSMS members would participate.

The strength that such unity would provide in any discussion with third party payers is obvious.

The principle is to be discussed at Councilor Conferences and a study committee of The Council has been appointed to explore the feasibility of developing such an agreement.

PROFESSIONAL LIABILITY INSURANCE

While there is no solutiuon to these problems that I can report, The Council has moved in some new directions in seeking remedies: (1) We continue to work with our insurance consultants on possible new coverages; (2) We have begun a dialogue with the State Bar of Michigan by means of a joint committee, raising several questions of interest to us in this area. The Bar association has been very cooperative in these efforts and we hope this approach will be of real value; (3) We have a continuing study of the possibility of starting our own MSMS insurance company; (4) and We have appointed a new Committee on Professional Liability to explore all the possibilities including panel review, arbitration, legislative relief, etc. This Committee, chaired by John W. Grigg, MD, has met several times and is working hard to develop ways to attack this important problem.

The outlook is not a rosy one, as yet, but this will be one of our most important objectives for the coming year.

MSMS MEMBERSHIP

Membership in MSMS on December 31, 1973 stood at 8,378 — a record figure. The gain over the previous year was modest, but many other professional societies are experiencing declining membership. Following are the MSMS membership figures:

Year	*June 30*	*Dec. 31*
1935	3410	3543
1945	4425	4686
1955	5503	6109
1960	6660	6715
1965	7247	7563
1970	7643	8062
1971	7645	8101
1972	7741	8168
1973	7856	8378

FINANCES

The Chairman of the Finance Committee, Ernest P.

Griffin, Jr., MD, will report verbally on this matter at the House meeting. Following is a Statement of Financial Condition from the MSMS audit for the 1973 fiscal year. It shows the status of our assets and liabilities and the resulting Members' Equity.

STATEMENT OF FINANCIAL CONDITION
NOVEMBER 30, 1973

ASSETS

CURRENT ASSETS

Michigan National Bank, Lansing, Michigan, commercial account	$ 8,919.18	
Office Cash	200.00	$ 9,119.18
Short term investments—commercial paper (Schedule 10)	342,259.52	
Less: Applicable to funded obligations	1,400.00	340,859.52
Accounts receivable: Advertising, reprints, etc.	13,642.66	
Due from employees—retirement plan	2,983.00	
Employee travel advances	2,600.00	19,255.66
Prepaid purchases of paintings (Note 2)		527.86
Prepaid expenses		6,132.16
Prepaid withholding taxes		2,010.10
TOTAL CURRENT ASSETS		377,874.48

FUNDED INVESTMENTS (Note 1)

Commercial paper	1,400.00	
Less funded obligation	1,400.00	-0-

PROPERTY AND EQUIPMENT (Schedule 11)

Land and building	677,886.82	
Furniture and equipment	118,866.04	
	796,752.86	
Less: Depreciation allowance	188,257.75	608,495.11

SOCIETY FUNDED INVESTMENTS

Capital Reserve Fund:		
Manufacturer's National Bank—principal and income cash	467.79	
Investments (Schedule 12) (Market value $437,069.00)	476,242.38	476,710.17
Capital Protection Fund:		
Manufacturer's National Bank—principal and income cash	1,275.56	
Investments (Schedule 13) (Market value $299,653.00)	363,100.97	364,376.53
TOTAL ASSETS		$1,827,456.29

Note 1: Funded obligation to retired Executive Director.

Note 2: The Society is contingently liable to the Michigan National Bank on a lease for decorative paintings with Mutual Leasing Company, in an amount of $3,201.77. The lease is payable at $105.14 per month, and expires in June, 1976.

LIABILITIES

CURRENT LIABILITIES

Mortgage payable—Michigan National Bank (current portion)	$ 52,356.00	
Payroll taxes due	134.16	
Unpaid invoices	32,678.66	
TOTAL CURRENT LIABILITIES	85,168.82	

LONG TERM DEBT—headquarters building:

Mortgage payable—Michigan National Bank	$587,926.52	
Less current portion (December 1973 through November, 1974)	52,356.00	535,570.52
TOTAL LIABILITIES		620,739.34

SOCIETY EQUITIES

GENERAL SOCIETY EQUITY

Balance—December 1, 1972	$267,633.92	
Net gain (loss) for period (Exhibit B)	97,996.33	
Balance—November 30, 1973		365,630.25

CAPITAL RESERVE FUND EQUITY

Balance—December 1, 1972	458,104.75	
Net increase for period (Exhibit B)	18,605.42	
Balance—November 30, 1973		476,710.17

CAPITAL PROTECTION FUND EQUITY

Balance—December 1, 1972	386,242.91	
Net decrease for period (Exhibit B)	(21,866.38)	
Balance—November 30, 1973	364,376.53	
TOTAL EQUITIES		1,206,716.95
TOTAL LIABILITIES AND EQUITIES		$1,817.456.29

NEED FOR EXPANDING HEADQUARTERS STAFF

This report regarding staff expansion has been approved by The Council. It is recommended to the House, and referred to the Ways and Means Committee. It concerns three specific areas: 1) legislation and agency contacts, 2) liaison with regional PSROs, and 3) member services and scientific activities. A copy of the report has been mailed to each Delegate and discussed at each Councilor Conference.

* * *

The Council wishes to commend the dedication and hard work of each of its individual Councilors, as well as the individual members of MSMS committees, the Michigan Delegation to the American Medical Association, and all who have had a part in helping The Council meet its responsibilities during the past months. The Council hopes for continued support of its efforts during the coming year.

(ADDENDUM TO ANNUAL REPORT OF THE COUNCIL, MSMS, TO THE HOUSE OF DELEGATES, MAY 5, 1974)

MSMS STATEMENT
Re: REGIONALIZATION

January 31, 1974

Honorable William G. Milliken
Governor, State of Michigan
State Capitol Building
Lansing, Michigan 48933

Dear Governor Milliken:

In your address to the House of Delegates of the Michigan State Medical Society October 9, 1973, you challenged MSMS as follows:

"Although it is an essential forerunner to innovation and change, policy is meaningless in the absence of concrete action. The next step will be to develop a blueprint for converting policy into action. When I say 'blueprint,' that is exactly what I mean. I take this opportunity to publicly challenge organized medicine, other provider associations, our professional schools and consumer groups to devise realistic implementation strategies for the regionalization of health services in addition to those already underway.

"Specifically, I would like your response to the following questions:

"—What services could better be provided on a regional as opposed to a community basis?

"—What manpower, facilities and special equipment would be required?

"—How should they be financed?

"—How would consumers know about these services and how could they reach them?

"—What role should areawide comprehensive health planning agencies and PSROs perform in the design and operation of these services?"

Attached is MSMS' initial response, in two chapters, as of this date. We intend to hope to continue to respond now and in the future. The first chapter deals with specific responses to the Governor's questions. The second is an approach to the philosophical response to the need and the problems inherent in regionalization.

It is MSMS' pleasure and privilege to submit the attached document, and to offer all assistance now and in the future in achieving the Governor's goals within the constraints of quality medical practice.

Very sincerely yours,

Robert M. Leitch, MD
Chairman of The Council

CHAPTER 1—RESPONSES

"WHAT SERVICES COULD *BETTER* BE PROVIDED ON A REGIONAL AS OPPOSED TO A COMMUNITY BASIS?"

It is impossible to simply list the services which would always work more efficiently on a regional basis than on a community basis. For the demography, the economics, the community sophistication, the modes of travel and other non-medical factors, all play roles in determining need. The basic criterion which must be met to justify regionalization should be: Can the service be provided by the community more effectively than by a region? The cost of equipment, the availability (or lack) of specialized medical personnel, the facilities, all come into question.

Services which generally may be more efficient, more qualified and more accessible on a regional basis include the categories of:

Renal disease (and transplantations).

Emergency services with intensive care units.

Neurosurgery.

Rehabilitation.

Burn units.

Cardiac care units.

Intensive care for high risk mothers and children.

Blood banks.

Radiotherapy and oncological services.

Conversely, what services can be more efficiently offered by the community than through regionalization, and using the same criteria, may include:

Primary care.

Office placement.

Elective procedures.

Most medical, surgical, obstetrical care.

Most emergency care.

Educational programs.

WHAT MANPOWER, FACILITIES AND SPECIAL EQUIPMENT WOULD BE REQUIRED?

Demands in personnel, equipment and cost must be related directly to the service in mind. There is no ratio or rule-of-thumb which can be overlaid to obtain a uniform answer. However, there are some obvious requirements:

Telecommunications.

Well-trained emergency medical technicians.

Intensive care-equipped ambulance services.

Appropriate medical specialists related to specific services.

Appropriate ancillary specialists related to specific services.

Ongoing evaluation.

HOW SHOULD THEY BE FINANCED?

Certainly it would be most desirable that private funding finance regionalized services, and probably it can. Certainly, with adequate forethought and planning, a regionalized service should extend, but not over-extend, the capacity of the population to support it. The first source of funding should be private funds. It should be recognized that many of these services are surrounded by an aura of drama and have great emotional appeal. The U.S. citizen has always responded generously to

such situations and philanthropy is responsible for many gains already made. Perhaps the greatest example of regionalization, culminating gloriously, was the national effort to eradicate polio. Second is insurance held by the patient, including private patients, Medicaid and Medicare, and other third-party payors who in today's society provide the accumulated funds for almost all major medical needs. A third source should still remain with the patient. That is co-pay or deductibles.

Only when private funds have been exhausted should the government enter with subsidies. This does not deny the need for government subsidy, but such aid should be limited to services whose cost requirements are so high as to preclude the private sector (i.e., long-term mental health care, rehabilitation). Perhaps a proper role is for the government to subsidize the unused capacity to provide a 7-day, 24-hour service.

In financing regional services, ultimate control of funds must be kept as close to the actual functioning service as possible, in order to achieve pre-established quality and cost control.

HOW WOULD CONSUMERS KNOW ABOUT THIS?

There is a peculiar trait to information about health and medical services which is almost unique. That is that, more than with any other requirement for good living (food, shelter, etc.), knowledge of a service becomes known by societal osmosis. A doctor may open an office in a new town, with no advance publicity or solicitation, and within a week his waiting room is full; a clinic opens its doors and a waiting line forms. This may lead to a problem not addressed in this paper: How to avoid overutilization of the service.

Nevertheless, there are ethical means of publicizing the regional service to appropriately inform the consumer. These include:

Media coverage, which would naturally ensue.

Use of existing institutions which would rely upon the service.

Public health departments.

Referrals from doctor participation.

WHAT ROLE SHOULD AREA-WIDE COMPREHENSIVE HEALTH PLANNING AGENCIES PERFORM IN THE DESIGN AND OPERATION OF THESE SERVICES?

Health planning certainly is one of the foremost things which can be done on a regional basis. Despite the sometimes disillusioning experiences with comprehensive health planning agencies (perhaps for failure to clearly identify the purposes of such agencies), there are significant roles these agencies can play. CHP should have the capacity to identify need and to provide consultation in preparing for implementation of a service and to make it certain it is consistent with other regionalizing plans. One of the failures of comprehensive health planning to date has been its resistance to use of the expertise of community medical personnel. **The role of the doctor in planning should be paramount.** Until the medical community (collectively) becomes the primary source of information for community, or regional, planning, successful use of comprehensive health planning will escape.

Professional Standards Review provides quite another hope, for despite the weaknesses in PSRO legislation, the responsibility for peer review is placed precisely where it ought to be: with the peer.

Current information is that Michigan will have no more than one or two operative PSROs in the immediate future. Real input by PSRO should not be anticipated before 1976 or 1977. When implemented and modified to the realities of medical practice, however, physicians expect that PSRO will provide data collection, education both for the practitioner and patient clientele, evaluation in terms of cost and quality performance, and importantly, identification and justification of services, again for both the provider and the patient.

CHAPTER 2

"PHILOSOPHY REGARDING REGIONALIZATION OF HEALTH SERVICES"

Prefatory Remarks

For the purposes of this response "regionalization" is defined as the process of organizing and operating certain medical facilities, procedures, and services which are unavailable to variable segments of the public by reason of extreme technical requirements, high cost and/or demographic barriers. The financing and personnel requirements of these services are such as to require certain minimal numbers of prospective users, frequently spread over large areas, to provide sufficient use for efficient delivery of the service with high quality and reasonable cost. By this definition a region might be as small as a small city or as large as the upper peninsula, depending on the service to be regionalized and the acceptable costs in its high quality delivery.

There are some excellent examples of successful existing regionalized health services. These are:

Regional burn centers in Ann Arbor, Detroit, Grand Rapids

Regional cardiac care units in most large communities, with instant referral systems to more highly sophisticated centers

Regional renal dialysis units in many communities

Regional neo-natal intensive care units

Regional rehabilitation centers

Regional blood banks

Regional emergency medical services

Regionalized resident and intern training programs.

These and other regionalized health services have five common factors:

1. They all have been developed in response to medical need.

2. They all respond to naturally occurring geographic and demographic requirements in meeting the need.

3. They all are expected to approach financial self-sustenance.

4. They all have been developed in a voluntary framework and are identified with the "private sector" of health care.

5. They all have been developed with professional health providers playing a responsible leadership role.

The real backbone of these **successful** regional programs is that the private sector has come to grips with a key consideration; namely, can the identified medical need be met on a cost effective basis? What is the trade-off between what the needed vital health service will provide and the dollars available to make its delivery economically realistic?

For example, the need for renal dialysis by certain kidney patients points up the dilemma. With dialysis a patient may effectively live; without it he will surely die. Are we willing to spend the dollars necessary to achieve life for every kidney patient in the State of Michigan? To what extent should the family, insurance companies, and government cover the necessary costs?

Less clearcut is the example of a patient with acute leukemia. With the best of treatment he most likely simply will have his life extended for a period of time, living not always happily to his death. Are we willing to spend the dollars necessary to achieve these added months of existence for every leukemia patient in the State of Michigan?

Alternative effective use of dollars, when cost-effectiveness of delivering a needed health service is doubtful, should surely be researched regarding the problems encountered. It may be that the diagnosis and treatment prevent effective use of dollars. It may be that problems of delivery are paramount. Each of these should be investigated in any total effort to better patient care.

The successful regionalized medical programs cited above also point out additional factors.

1. It is probably not necessary to regionalize a given service throughout the state since some areas are already well served.

2. The region for one service probably will be totally different from the region for another, since the availability and character of the service itself, its costs, its personnel requirements and its geo-economics vary greatly.

Thus, rigid, state-wide, co-terminal regional areas do not appear to offer efficient delivery of a full scope of health services. A series of interlocking regions, each addressing itself to delivery of specific services for a specific population, is the proper approach.

The fact that the successful existing regional programs tend to be self-sufficient, enjoy multiple source cooperation, and are highly regarded by involved persons suggests that there is need to guard against poorly conceived regionalization plans.

This does not say that regionalization of health services should not be extended. It does say that it must be done in a deliberate, knowledgeable manner by individuals who are or will be involved in the extension. It is a team project, a partnership whose goal is to identify and deliver cost-effective, regionalized needed medical services.

Presumably some of the regionalized service extension which should occur can only occur with the help of resources from government. Thus, government becomes a partner. Government could play one or more of several partnership roles, including that of financial backer, legal vehicle or simply the quality control interest.

CONCLUSION

This document has introduced some concepts to the physician's approach to regionalized health service delivery systems. They are:

1. Cost—Effectiveness

2. Service determined concentric interlocking regions, and

3. A partnership of committed parties.

There have been examples cited that include the above, plus some additional concepts which are necessary ingredients in successful regionalization. The successful regionalized service is:

1. Developed in response to need.

2. Oriented to geographic, demographic and other factors influencing the service.

3. Expected to approach financial self-sufficiency.

4. Identified with a cooperative effort which may include public, private, and governmental interests.

5. Developed through a predominant and responsible role by health providers.

Regionalization should strive for:

1. Improved accessibility to quality health care by all citizens.

2. Reduction of socio-economic and geographical barriers to quality health service.

3. Simplification and expedition of referrals.

4. Improved availability of appropriate health care facilities and programs other than those of the acute hospital.

Three criteria must be applied when deciding to choose between local or the regional route — Will regionalization:

1. Improve availability over local delivery?

2. Be less costly than local delivery?

3. Be of equal or higher quality than local delivery?

Finally, the worst possible error would be to regionalize a service without appropriate information and clearly identified goals and problems. It is certain that an unsuccessful regionalized service program would result. The dollar cost could be staggering, discontent of the patient and provider alike would be appalling, and good health care would be sacrificed.

Unfortunately, it seems that every time the subject of regionalization comes up, it ends up with someone concluding that only by placing control in the hands of government can it be done. The examples of private regionalization of services in the first section of this paper speak strongly against government involvement. Private medicine, both doctors and hospitals, ought to control the development of regionalized services. In fact, many physicians now are beginning to believe that unless organized medicine is given a much larger, much louder voice in regionalization, among many other changes in health care delivery, they will not speak at all.

Michigan's doctors of medicine are prepared to provide their expertise to make appropriate goals of regionalized health care realizable and a great ac-

complishment for our state. Perhaps the time to help has come and our professional counsel will be honored.

COMMITTEE REPORTS

16. Reports of House of Delegates Committees

COMMITTEE ON CERTIFICATES OF COMMENDATION

Richard J. McMurray, MD, Chairman

The MSMS House of Delegates in 1961 established the MSMS Certificates of Commendation. The original action instructed that the awards "may include both scientific and/or public services, and may be awarded to one or several physicians annually who distinguish themselves in the medical profession." The first awards were presented in 1962 and thus far sixty-three physicians have been recipients of Certificates of Commendation.

This year the Committee again invited each component medical society to submit nominations. The Committee thoroughly reviewed all nominees and, after much thoughtful deliberation, selected three candidates for the delegates' consideration.

The Committee is proud to recommend the names of the following outstanding Michigan doctors for Certificates of Commendation:

James R. Doty, MD, of Lapeer
C. Allen Payne, MD, of Grand Rapids
Clayton K. Stroup, MD, of Flint

Here are short biographies for your review:

JAMES R. DOTY, MD

James R. Doty, MD, of Lapeer, was born in Newark, New Jersey in February 1912, he took his pre-medical training at the University of Michigan and the University of Tennessee, received his medical degreee from Wayne State University in 1942. He served his internship and residency in ophthalmology at Receiving Hospital in Detroit. He then moved to Lapeer where he has practiced for 28 years. He is affiliated with Lapeer County General Hospital, where he was Chief of Ophthalmology and Otolaryngology for 20 years, Chief of Staff for two years, and Secretary and member of the Medical Board for seven years; the Lapeer State Home Hospital where he served as chief of EENT for 24 years; and McLaren Hospital in Flint. Doctor Doty has served as Secretary-Treasurer and as President of the Lapeer County Medical Society, the Michigan Triological Society, and the Saginaw Valley Academy of Ophthalmology and Otolaryngology, was a member of the MSMS House of Delegates for seven years, and was Health Officer for the City of Lapeer for seven years. Doctor Doty was one of the first physicians in Michigan to promote the concept and help bring about the establishment of a combined hospital staff.

In addition, Doctor Doty has been a Vestryman in his church and a member of the Lapeer Board of Education. Doctor Doty has given freely of his time to serve the children at the Lapeer State Home Hospital.

C. ALLEN PAYNE, MD

C. Allen Payne, MD, was born in Laurium, Michigan in March 1909. He received his B.S. in 1931 from Hahnemann College of Science, in Philadelphia, and his medical degree two years later from Hahnemann Medical College. He interned at Miami Valley Hospital in Dayton, Ohio, and served his residency in pathology at Methodist Hospital in Indianapolis and Henry Ford Hospital in Detroit.

Doctor Payne was certified in Clinical Pathology and Pathologic Anatomy in 1938 and since that date has served as Director of Laboratories at Blodgett Memorial Hospital in Grand Rapids. He also serves as Chairman of the Department of Hospital Medical Services at Blodgett as well as Consultant in Pathology to United Memorial Hospital in Greenville, and also the Kent Community and Pine Rest Christian Hospitals in Grand Rapids. He served on the MSMS Council for ten years, was a member of the MSMS Judicial Commission, and was President of the Michigan State Medical Society in 1966-67. In addition, Doctor Payne has served on numerous committees of MSMS throughout the years. He has been an active participant in the activities of the Kent County Medical Society, Michigan Pathological Society, Michigan Division of the American Cancer Society, plus many other medical and voluntary health organizations. Through his efforts, a combined blood program is a reality in Kent County. Doctor Payne was appointed to the Michigan State Board of Registration in Medicine (now the Michigan Medical Practice Board) in 1963 and has been its President since 1969; was appointed to the Governor's Advisory Commission on Physician Assistants; and serves as Director of the newly established Grand Valley Blood Program.

CLAYTON K. STROUP, MD

Clayton K. Stroup, MD, was born in October 1902 in Russelsprings, Kansas. He received his B.S. and M.D. degrees from the University of Oklahoma, graduating in 1926. Doctor Stroup interned at Harper Hospital in Detroit, and served his residency in Internal Medicine at Highland Park General Hospital. In addition, he has done postgraduate work in alcoholism, gastroenterology, hepatology, and internal medicine at the University of Michigan, New York Post Graduate Hospital, Tulane University, Tokyo Cancer Institute and Cook County Hospital. Doctor Stroup, a Flint practitioner for 46 years, was a pioneer in the diagnosis and treatment and has attracted international recognition for his contributions toward the establishment of professional alcoholism programs. He is Director of the Alcoholism Therapy Program at Hurley Hospital, Chief of Gastroenterology at McLaren General, and Chief of Internal Medicine at St. Joseph Hospital. He also has contributed his time to the Community Planning Committee for Senior Citizens, Insight, Inc., (Medical Director and Chairman of the Board since 1965), Genesee County Drug Abuse Commission, and other civic groups. He has served as President of the Genesee County Medical Society and the Michigan Society of Internal Medicine, and was a member of the MSMS House of Delegates.

In addition to his pioneer work in alcoholism, Doctor Stroup also is well recognized for his contribution in the field of gastroenterology, being the first physician in the Flint area to practice gastric endoscopy.

THE HOUSE, acting as a committee of the whole, approved the report of the Committee. Certificates of Commendation were presented to Doctors James R. Doty, C. Allen Payne and Clayton K. Stroup.

Committee on Constitution and Bylaws

The following proposed Constitution & Bylaws changes were adopted on first reading by the Fall 1973 House of Delegates and are presented here for final consideration:

1. MSMS Purposes

PROPOSED AMENDMENT: Amend Article II of the Constitution to read: Sec. 1 — PURPOSES — The purposes of this Society shall be: To bring into one viable, effective organization the ethical physicians licensed to practice in Michigan in order that their contribution to human welfare will be enhanced.

In order to accomplish this effectively, the Society also will work to accomplish the following sub-purposes:

A. To constitute, support and advise the American Medical Association in cooperation with similar societies of other states, in meeting its appropriate responsibilities.

B. To charter and organize constituent component medical societies.

C. To conceive, develop and administer health education programs designed to improve public understanding, awareness and acceptance of good medical standards, practices and concepts, as they relate to personal health, scientific progress and society's advancement.

D. To stimulate advancement of the science and art of medicine and continually to seek to advance the medical, scientific, social, environmental, economic and medical political knowledge of its members in order that the doctor may better serve his patients and the public health generally.

E. To aid Michigan physicians individually and collectively in maintaining high levels of ethical conduct and standards of practice to protect and serve the total public.

F. To provide medical leadership in meeting the health needs of the people by working with other medical and non-medical groups and individuals.

G. To preserve, protect and enhance physician-patient relationships, as basic to the delivery of quality health care.

H. To promote quality medical and health care by development and support of activities appropriate to this goal.

I. To advocate fair remuneration for services rendered.

J. To ensure the adequacy of medical manpower by attracting capable people into the medical and health professions and to work toward the most effective distribution of their services.

K. To encourage medical students and physicians-in-training to participate in organized medicine in order to enable MSMS to be representative of all physicians.

L. To support the efforts of those who would preserve, protect and enhance the reputation and services of the medical profession.

M. To institute and provide specific services to meet the needs of the members.

N. To foster and support continuing medical education.

COMMENT: These Purposes, as presented by the MSMS Committee on Planning and Priorities, were adopted on first reading by the Fall 1973 House of Delegates.

RECOMMENDATION: That this Constitutional amendment be adopted on second reading.

2. Deletion of Article VIII of the Constitution.

PROPOSED AMENDMENT: That this Article be deleted from the Constitution and subsequent Articles be appropriately renumbered.

COMMENT: This Article lists various classifications of members within the Society and appears to be unnecessary since it is repetitious of the Bylaws. If it is not deleted, it would be necessary to revise the list of classifications to agree with the Bylaws.

RECOMMENDATION: That this Constitutional amendment be adopted on second reading.

3. Revision of Sec. 1, Article XIII of the Constitution.

PROPOSED AMENDMENT: Amend this Article as follows: Sec. 1 — METHOD OF AMENDMENT — The House of Delegates may amend any article of this Constitution by a two-thirds vote of the Delegates seated at any REGULAR Session, provided that such amendment shall have been presented in open meeting at the previous REGULAR Session, and that it shall have been published at least once during the INTERVAL in the *Journal* of the Society, or sent officially to each component society at least two months before the meeting at which final action is to be taken.

COMMENT: This amendment is recommended so that matters requiring both Constitutional and Bylaws amendments can be acted on at regular sessions other than the Annual Meeting, in the event there is more than one regular House meeting in one year.

RECOMMENDATION: That this Constitutional amendment be adopted on second reading.

4. Proposed Revision of Chapter 2 — Membership Classifications.

At the Fall 1973 House of Delegates meeting, this proposed revision was approved on first reading.

PROPOSED AMENDMENT: That Chapter 2 of the MSMS Bylaws be revised to read as follows, and that Sections 8 and 9 of Chapter 5 be deleted: CHAPTER 2 — MEMBERSHIP — CLASSIFICATION — ELECTION.

Sec. 1. DEFINITION—As used in these Bylaws, except as otherwise herein expressly qualified, whenever the terms "doctor of medicine" of "practice of medicine" or "medical profession" are used, these terms shall be deemed to include the terms "doctor of medicine and doctor of osteopathy," "practice of medicine and practice of osteopathy," and "medical profession and osteopathic profession."

Sec. 2. MEMBERSHIP PREREQUISITE — All members of the several component societies, when in good standing, are thereby and must be members of

this Society.

Sec. 3. ACTIVE MEMBERS — To be eligible for active membership in any component society, a doctor of medicine must hold an unrevoked permanent license in Michigan, or, if unlicensed, must be engaged in academic teaching, research or administration. To maintain active membership in any component society, a doctor of medicine must maintain active membership in this Society and comply with all the provisions of the Bylaws of this Society and the component society. Physicians-in-training may become active members if they hold permanent licenses.

Sec. 4. ACTIVE MEMBERS — DUES EXEMPT — A member in any of the following three categories shall be classified as "Active — Dues Exempt" and shall have all the privileges of active membership:

(a) Hardship — A member for whom the payment of dues would be a financial hardship by reason of physician disability or illness may be excused, fully or partially, from payment of dues by The Council provided the member is fully or partially exempted from the payment of component society dues. A member may also be excused from payment of dues because of financial hardship, or for other reason, but these must be set forth by the secretary of the member's component society.

(b) Postgraduate Study — Active membership may be maintained without payment of dues for any member who is out of practice on account of postgraduate medical studies or in an approved residency training program providing such dues exemption is given by the component medical society.

(c) Voluntary Service — A member who serves as a missionary or who participates, for nominal or no compensation in a government-sponsored volunteer medical program, either in the United States or abroad.

Sec. 5. PHYSICIANS-IN-TRAINING

(a) Active — Component societies may admit to membership physicians still in training who have permanent licenses to practice medicine in Michigan. Such members shall have all privileges of active membership. State Society dues shall be reduced to 50% of the regular dues for active members, and component society dues shall be set locally.

(b) Associate — Physicians-in-training who have permanent licenses to practice medicine in Michigan may become associate members of the component society and of the State Society, with all membership privileges except the right to vote or hold office. State Society dues shall be set by The Council to cover administrative costs of membership, and component society dues shall be set locally.

Sec. 6. TEMPORARY LICENSEES AND STUDENTS—Component societies may admit to membership medical students, and physicians-in-training who do not have a permanent license, as Student Members. Student members shall not pay dues to this Society nor the component society. They may receive MSMS publications authorized by The Council. They may not vote or hold office, nor be eligible for other member benefits. They may be appointed to MSMS committees as advisors.

Sec. 7. RETIRED MEMBERS — A member who has maintained active membership in any one or more component societies in Michigan for a period of five or more years, and who has retired from practice, may be transferred to the retired members roster of such component society, provided his membership dues have been paid to the end of the preceding calendar year. A retired member shall pay no dues or assessments, but shall have the right to vote and hold office, and shall be entitled to receive publications at such rates as The Council may determine.

Upon request of the component society made at least thirty days in advance of an Annual Session of the House of Delegates and upon certification by the Secretary of this Society as to number of years of practice and membership in good standing, the House of Delegates may elect such member to retired membership in the Society.

Sec. 8. LIFE MEMBERS

(a) A doctor of medicine who has maintained an active membership in good standing for twenty-five years in any one or more constituent state societies of the American Medical Association, with any five years in Michigan, with dues paid for the previous calendar year and who 1) has attained the age of 70 years or 2) has been in practice for 50 years, may, upon application and recommendation of his component society made at least 30 days in advance of an Annual Session of the House of Delegates, be elected by the House of Delegates to life membership in this Society. Such election shall be preceded by certification of the State Society in which he has maintained membership as to the required number of years of membership and good standing.

(b) Upon the adoption of this subdivision (b) all then living Past Presidents, Past Chairmen of The Council and Past Speakers of the House of Delegates of this Society shall automatically become life members of this Society and thereafter each President, Chairman of The Council and Speaker of the House of Delegates of this Society shall, upon retiring from office, become a life member of this Society without further action.

(c) A life member shall pay no dues or assessments but shall have the right to vote and hold office and shall be entitled to receive publications at such rates as The Council may determine.

Sec. 9. SERVICE MEMBERS

(a) Military — A member in good standing who serves on active duty in the military forces of the United States may be transferred by the component society to Service Member status for the period of time he is in such service.

(b) Commissioned medical officers — A commissioned medical officer of the United States Army, Navy, Public Health Service, or physician employed by the Veterans Administration, on

duty in this State, who is not engaged in the private practice of medicine, may be granted Service Member status by the component society in the area where he is located.

Service members shall pay no dues and are not entitled to vote or hold office. They shall be entitled to receive publications at such rates as The Council may determine.

Sec. 10. HONORARY MEMBERS — A component society may elect as an honorary member any person distinguished for his services or attainments in medicine or the allied sciences, or who has rendered other services of unusual value to organized medicine or the medical profession. Upon recommendation of a component society, the House of Delegates may elect such person an honorary member of the Society. An honorary member shall pay no dues and shall be without the right to vote or hold office in either this or the component society.

Sec. 11. NON-RESIDENT MEMBERS — A component society may elect as a non-resident member any doctor of medicine residing and practicing outside of the county who is a member in good standing of his own Michigan component society. A non-resident member shall not have the right to vote or hold office.

Sec. 12. AFFILIATE MEMBERS — Component societies may elect to affiliate membership lay persons in areas of endeavor which are related to medicine and medical practice. Affiliate members shall pay no dues and may not vote or hold office. They shall be entitled to receive publications at such rates as The Council may determine.

Sec. 13. RESOLUTIONS CONCERNING MEMBERSHIP CHANGES — Any change in membership status which requires action by the House of Delegates shall be effected by resolution presented in triplicate at an Annual Session of the House of Delegates after such secretarial certification as is required by these Bylaws.

COMMENT: The Committee believes that the membership classifications as now contained in the Bylaws are confusing, sometimes overlap, and should be modified to meet present needs.

The major changes recommended are:

(1) *Establishment of a New Category "Active Members — Dues Exempt."* This will include present provisions re exemption for hardship and for postgraduate study, now contained in Chapter 5. It also includes a dues-exempt category for physicians who serve as missionaries or in government-sponsored volunteer programs.

(2) *Deletion of the Associate Member Category.* Persons now included in this category will be eligible for membership under other sections in the new Chapter.

(3) *Addition of Membership Category for "Students."* This category would allow medical students or physicians-in-training who do not hold permanent licenses to become student members. They would not be able to vote or hold office, nor be eligible for other member benefits. They would be permitted to serve on MSMS committees as advisors and would receive MSMS publications as authorized by The Council.

(4) *Establishment of a New Category "Service Members."* This would include previous categories of military members and commissioned medical officers.

(5) *Addition of Membership Category for "Affiliate Members."* This includes some members presently included under Associate Members and allows component societies to admit to membership lay persons in areas of endeavor related to medicine and medical practice. Such members would not vote or hold office.

(6) *Addition of Membership Category for "Physicians-In-Training."* Provides permanently licensed physicians-in-training with the option of 1) active membership with full privileges with MSMS dues reduced to 50% and local dues to be set by the component society, or 2) associate membership with all privileges except the right to vote and hold office, with MSMS dues to cover costs of member benefits, and local dues set by the component society.

Other minor changes in Chapter 2 include clarification of language re the necessity of being a member of MSMS to be a member of the component society and vice versa, minor changes in the provisions for retired membership, and other "housekeeping" changes.

A brief outline of the proposed new Membership Classifications is:

Category	Requirement	Limitation of Privileges
1 ACTIVE full dues	MD or DO, Licensed or in academic teaching, research or administration	None
2. ACTIVE DUES-EXEMPT a) Hardship (partial or no dues) b) Postgraduate study (no dues) c) Missionary or government-sponsored volunteer program	MD or DO, Licensed or in academic teaching, research or administration	None
3. PHYSICIANS-IN-TRAINING a) Active 50% MSMS dues CMS sets local dues	Permanently licensed MD or DO still in training	a) None

Category	Requirement	Limitation of Privileges
b) Associate MSMS dues to cover cost of membership benefits. CMS sets local dues		b) May not vote or hold office
4. STUDENTS no dues	Medical student or physician-in-training who is not fully licensed	May not vote or hold office. Not eligible for other member benefits. Publications authorized by The Council
5. RETIRED MEMBERS no dues	Active member in Michigan for 5 yrs. Retired from practice. Dues paid to end of preceding calendar year	Same as active except must subscribe to publications
6. LIFE MEMBERS no dues	1) 70 yrs. old or 50 yrs. in practice, active membership in AMA constituent for 25 yrs. (5 in Mich.), dues paid for previous calendar yr., recommended by component society OR 2) MSMS Past Presidents, Council Chairmen and Speakers	Same as active except must subscribe to publications
7. SERVICE MEMBERS a) Military (no dues) b) Commissioned medical officers (no dues)	a) Active military service b) Commissioned officer in US Army, Navy, Public Health Service, or physician employed by Veterans Administration, in Michigan	May not vote or hold office. May subscribe to publications
8. HONORARY MEMBERS no dues	Distinguished service or attainments in medicine or allied sciences.	May not vote or hold office. May subscribe to publications
9. AFFILIATE MEMBERS no dues	Lay persons in areas of endeavor related to medicine	May not vote or hold office. May subscribe to publications
10. NON-RESIDENT MEMBERS	Selected by county	May not vote or hold office. Member Mich. CMS

RECOMMENDATION: That the revised Chapter 2 be adopted on second reading.

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Last fall the Committee presented on second reading an amendment to establish a Section on Clinical Pharmacology & Therapeutics in order to conform with a similar AMA section. The amendment had been adopted on first reading at the previous meeting of the House. However, when it was presented for second reading, a question was raised as to the number of physicians who would be involved in such a section and, since the information was not immediately available, action on the amendment was deferred.

Subsequently, the Committee has learned that the proposed section would have approximately 50 members and that, rather than detracting from attendance at other sections, it would strive to contribute to programming in areas of joint interest with other sections.

proposed amendment; That Chapter 14, Sec. 1, of the MSMS Bylaws, be amended by adding to the list of sections "Clinical Pharmacology and Therapeutics."

RECOMMENDATION: That this Bylaws amendment be adopted on second reading.

THE HOUSE approved on final reading all the Constitution & Bylaws changes presented in the foregoing report.

REPORT OF THE REFERENCE COMMITTEE ON WAYS & MEANS

David Siegel, MD, Chairman

(Note: This report explains why the House Ways and Means Committee is recommending a dues increase beginning in 1975 to cover the rising costs of regular MSMS business and to permit MSMS to expand its staff.)

The Committee met on March 27, 1974, with the following invited guests:

Ernest P. Griffin, Jr., MD, Chairman of the Finance Committee
John R. Ylvisaker, MD, Treasurer
Kenneth Knostman, CPA, Auditor
Warren F. Tryloff, MSMS Director
John Anthony, MSMS, Chief of the Bureau of Economic Information

1. The Chairman reviewed the Committee's report to the House in October, 1973, which set forth the responsibility of the Ways and Means Committee:

a. Primary duty to furnish cost estimates to the House on all resolutions requiring expenditure of funds prior to final action by the House.

b. Serve as financial overseer for the House in reviewing actions taken by officers and The Council having a financial impact on the membership.

c. Review general fiscal policies to assure itself of appropriateness.

2. The 1973 audit of MSMS financial affairs was reviewed by Kenneth Knostman, C.P.A., who answered questions and assured the Committee that the finances of the Society were being handled in an appropriate manner.

3. The three funds of MSMS were reviewed:

a. The Operating Fund used to finance annual MSMS operations.

b. The Capital Reserve Fund which serves as funding for depreciation of building, fur-

nishing, and equipment.

c. The Creative Reserve Fund serving as a research and development fund, available to finance important projects of MSMS.

The principles by which the funds were managed were reviewed along with the performance of each for the year.

4. *MSMS Budget Process.*

The preparation of the MSMS annual budget takes several weeks and hundreds of man-hours of labor by the Finance Committee and staff. Over two hundred revenue and expense accounts are developed in the meticulous process. The budget process starts with each department submitting a detailed explanation of each account for which it is responsible, through contact with committee chairmen, officers, etc. Each year, many new proposals are included that better meet the Society's objectives. These detailed requests are then assembled into a preliminary budget.

The Budget Committee then makes a realistic estimate of MSMS income for the coming year, reviews budget requests, and trims the proposals to equal income.

When the Budget Committee feels convinced it has the best possible budget for the fiscal year, it goes to the Finance Committee and The Council for amendment and final adoption.

5. *Increased Cost of Doing Business.*

The Ways and Means Committee discussed the increased cost of doing regular business and noted the following selected examples of increases in expenses. It was pointed out that the Consumer Price Index rose 8.8% in 1973.

The Committee was told that income of MSMS normally rises at a rate of 1% due to increased membership. Increased cost for 1974-75 will be approximately 4-4½% per annum. This figure was at this relatively low level because not all expense items will increase, for example, the mortgage payments. This is more than counterbalanced by a 20% increase in postage cost.

SAMPLE OF INCREASED EXPENSES

Expense	*1972*	*1973*	*% Increase*
Telephone	$16,958	$18,733	10.5%
Real Estate Taxes	27,333	29,473	7.8%
Utilities & Building Maintenance	40,188	43,860	9.1%
Employee Health Care Premiums	8,983	10,403	15.8%

Estimates for increases in 1974 exceed those reached in 1973.

6. *Recommendations from The Council regarding the Expansion of the MSMS Staff.*

A detailed report was received from The Council recommending additional staff in three specific areas (1) legislation and agency contact, (2) liaison with regional PSROs, and (3) member services and scientific activities.

The Council's study of staff was begun by the Budget Committee in August, 1973. On January 30, 1974, a motion to expand staff was referred to the Finance Committee to expedite the study. In March, the Finance Committee's recommendations were adopted by The Council of MSMS and referred to the House Ways and Means Committee for review and recommendations re funding.

The recommendations of The Council are being sent to each Delegate along with the Ways and Means Committee's recommendation for funding. By motion, the Ways and Means Committee approved of expanding the staff and approved of The Council's recommendation for the addition of two persons in the Department of Legislative Affairs, one person in the Department of Peer Review and a manager and one secretary in the Department of Member Services and Scientific Activities.

7. *Costs and Methods of Funding.*

Historically, the dues level has held for three or four years as shown in the chart below. Incremental increases have averaged in the area of 30%. Since our last increase, the cost of doing business has advanced 4% per year.

Michigan State Medical Society Dues

Year	*Dues*	*Per cent Change From Previous Amount*
1970-1974	$135	35%
1965-1969	$100	25%
1960-1964	$ 80	33%
1955-1959	$ 60	33%
1950-1954	$ 45	22%

An increase from $135 to $155 is 14.8 per cent.

There are 13 medical societies that have annual dues higher than MSMS.

Michigan ranks eight in total number of physicians.

Cost of staff expansion and inflation:

Proposed Staff Changes:

Government Relations (2 persons)	$ 60,000
Membership & Scientific Activity (2 persons)	44,000
Peer Review (1 person)	23,000
Sub-total	$127,000
Inflation factor (4% of estimated million dollar budget)	40,000
	$167,000

The Committee explored various alternatives of funding and forecast deficits in the future with various increases in dues. It also explored the possible appropriate uses of income from the Creative Reserve (Capital Protection) Fund. It was deemed that since this fund was in the nature of a research and development fund, it would be appropriate to utilize this to fund the required MSMS staff addition for liaison with PSROs.

MOTION: That monies be transferred from the Creative Reserve Fund to finance the costs of an additional staff person to the Peer Review Department estimated in 1975 to cost $23,000; carried.

MOTION: That the dues be increased by $20.00 beginning in 1975 from $135 to $155, a 14.8% increase, to help provide the monies to finance additional staff members and the increased cost of doing business; carried.

Method of Funding:

Dues Increase 6,800 at $20	$136,000
From Creative Reserve Fund	23,000
From Operating Fund Balance	8,000
TOTAL	$167,000

The Committee projected that the adoption of such a plan would mean that no additional new dues money would be required, at the present state of activity, until 1979.

MSMS FINANCIAL PROJECTION

(000's omitted)

	1974	*1975*	*1976*	*1977*	*1978*
Revenue	$1,028	$1,164[1]	$1,173	$1,183	$1,194
Expenses	1,000	1,144[2]	1,190[3]	1,238[3]	1,287[3]
Net Income	$ 28	$ 20	$ (17)[4]	$ (55)[4]	$ (93)[4]

[1]Reflects a $20 dues increase (6,800 at $20 = $136,000).

[2]Increase of $104,000 for staff changes (excludes $23,000 for Peer Review) and $40,000 for inflation.

[3]Increase due to 4% inflation factor.

[4]Will be funded from current operating fund balance.

8. *Information to the Delegates.*

The Committee agreed that all information re these recommendations should be sent to all Delegates promptly and that the reports of The Council and this Committee should be discussed and explained at Councilor Conferences.

The Committee will meet as a Reference Committee on Monday, May 6, and then deliver its final report to the House on Tuesday, May 7.

THE HOUSE approved a recommendation that monies be transferred from the Creative Reserve Fund to finance the costs of an additional staff person to the Peer Review Department estimated in 1975 to cost $23,000.

THE HOUSE approved a recommendation that the dues be increased by $20 beginning in 1975 from $135 to $155 to provide the monies to finance additional staff members and the increased cost of doing business.

RESOLUTIONS

• RESOLUTION 74A-1 (formerly 72A-10 — resubmitted as directed by the 1973 House of Delegates)

Exploitation of physicians
Donald Bryan, MD, Wayne County

House Action: Substitute Resolution (in lieu of 74A-1, 74A-2 and 74A-31) Adopted

Whereas, the principles of medical ethics of the American Medical Association state that the principles governing groups and clinics and professional corporations are the same as those applicable to the individual, and

Whereas, changes in structure of health care financing, and changes in the organization of health care delivery are contemplated, with employed physicians assuming an ever more important part of these structures, and

Whereas, Judicial Opinions and Reports of the American Medical Association, Sections 6 and 7, proscribe the sale of medical services for direct profit, of a lay group; proscribe the disposal of a physician's services to any hospital, corporation, or lay group by whatever name which permits the sale of the services of that physician, and prohibits the unethical division of fees between physicians, and

Whereas, there are clinics and emergency room corporations and others, which have refused to give the patient the name of his or her attending physician, which action violates the basic principle of free choice, and

Whereas, some hospitals are now requiring attending staff members to care for patients in the outpatient departments or emergency rooms as a requirement of staff membership, therefore be it

RESOLVED: That the Michigan State Medical Society deplore and condemn the exploitation of physicians and physicians' services for profit and be it further

RESOLVED: That the Michigan State Medical Society reaffirm the concept that a physician who allows his services to be used by any agent in an unethical manner is himself in violation of the principles of medical ethics.

• RESOLUTION 74A-2 (formerly 72A-2 — resubmitted as directed by the 1973 House of Delegates)

Physician Service in Outpatient Departments
Ralph Cooper, MD, Wayne County

House Action: Substitute Resolution (in lieu of 74A-1, 74A-2 and 74A-31) Adopted. See 74A-1

• RESOLUTION 74A-3

Uniform Billing Practices
John B. Bryan, MD, Oakland County

House Action: Substitute Resolution (in lieu of 74A-3, 74A-4, 74A-8, 74A-9, 74A-36, 74A-44, 74A-45 and 74A-46) Adopted as Amended.

Whereas, there has been a longstanding need for a uniform billing form and coding form, and

Whereas, physician reimbursement has presented a problem not only to physicians but to patients as well, therefore be it

RESOLVED: That the Chairman of The Council, the President of MSMS and the Speaker of the House of Delegates immediately appoint a representative committee consisting of 10 members of the House of Delegates and that this Committee be empowered to recruit additional MSMS members at large if needed and to negotiate and begin implementation with any or all third party payors within 120 days:

1. The adoption of a uniform coding system by all third party payors.
2. The use of a uniform health insurance claim form by all third party payors.
3. The abolishment of discriminatory reimbursement practices.
4. To identify and resolve other closely related problems.

If these objectives cannot be accomplished through negotiation, the Committee may recommend to The

Council such action as:

1. Statewide "non-participation" by members of MSMS
2. Legal action
3. Other appropriate courses of action that may be deemed necessary by the Committee

This Committee has the authority of the House of Delegates to act with The Council's approval and is instructed to issue written progress reports to the Speaker, to the members of the House of Delegates and to The Council for their advice and assistance.

The House of Delegates also authorizes The Council to provide adequate staff, financial support and direction to this Committee, and be it further

RESOLVED: That this Committee hold its first meeting within 30 days after the adjournment of this House of Delegates, and be it further

RESOLVED: That this Committee begin to negotiate these problems within 30 days after its organizational meeting.

• **RESOLUTION 74A-4**

Profiles of Usual and Customary Fees
John B. Bryan, MD, Oakland County

House Action: Substitute Resolution (in lieu of 74A-3, 74A-4, 74A-8, 74A-9, 74A-36, 74A-44, 74A-45 and 74A-46) Adopted as Amended. See 74A-3.

• **RESOLUTION 74A-5**

Documentation of Insurance Benefits
John M. Wood, MD, Isabella-Clare

House Action: No Action

Whereas, there has been a well organized and significantly effective advertising program through the public news media to imply that any physician's charges that are above those established by a third party insurance carrier are, in fact, unjustified and unreasonable, and

Whereas, there is a significant discrepancy in third party fees paid in different geographical areas, and

Whereas, there is no way that either the consumer or the provider may obtain access to these varying, changing, and arbitrary fee schedules, therefore be it

RESOLVED: That MSMS seek to have, either by legislation or regulation, standards which will be applied by the Insurance Commission of the State of Michigan that will require all companies selling health insurance to the citizens of Michigan to state specifically the dollar amounts which are allowable for each and every documentable health service covered, and be it further

RESOLVED: That circumstances, if any, under which the service would not be considered a benefit be specifically included in their policy and in their promotional material, and be it further

RESOLVED: That the same availability of fee schedules be made available for all Medicaid and Medicare benefits.

• **RESOLUTION 74A-6**

Re-certification
Worth W. Henderson, MD, Oakland County

House Action: Disapproved

Whereas, Michigan State Medical Society has constantly striven to improve medical care within the State of Michigan, and

Whereas, Michigan State Medical Society has been a leader in fostering changes that would accomplish this, and

Whereas, advances in medical care are occurring at an accelerated rate, therefore be it

RESOLVED: That Michigan State Medical Society appoint a committee to work with the specialty boards and the Medical Practice Board to arrive at a program for continued medical education, and be it further

RESOLVED: That Michigan State Medical Society develop a program to be implemented by the Medical Practice Board that a specific number of hours of continued medical education be required for re-certification, and be it further

RESOLVED: That re-certification occur at a minimum of three years or a maximum of five years for each individual practitioner.

• **RESOLUTION 74A-7**

PSRO
George Koepke, MD, Washtenaw County

House Action: Substitute Resolution (in lieu of 74A-7, 74A-21 and 74A-26) Adopted

Whereas, The Support Center will provide:

1. Education and initial assistance for local PSROs.
2. Affirmative education through the publication of *Michigan Medicine.*
3. Development of organizational format and structures.
4. Assistance in recruitment of physician and staff members.
5. Consultation for problems.
6. Educational, legal, and reference material.
7. Field monitoring of all state PSROs.
8. Development of a PSRO appeal mechanism.

and

Whereas, a proposal for such a center has been submitted to the Department of HEW on April 30, 1974, in order to meet a deadline, therefore be it

RESOLVED: That the House of Delegates approve the concept of the Statewide Support Center, and be it further

RESOLVED: That the House of Delegates approve the action of The Council in submitting a proposal to HEW for funding of a Statewide PSRO Support Unit. This center is to offer technical and administrative assistance to PSROs and assist in negotiations of contracts with the OPSR.

• **RESOLUTION 74A-8**

Michigan State Medical Society Mediation Committee to Third Party Payors
Donald K. Crandall, MD, Muskegon County

House Action: Substitute Resolution (in lieu of 74A-3, 74A-

4, 74A-8, 74A-9, 74A-36, 74A-44, 74A-45 and 74A-46) Adopted as Amended. See 74A-3.

• **RESOLUTION 74A-9**

MSMS Support for the Uniform Health Insurance Claim Form
Henry A. Kallet, MD, Jackson County

House Action: Substitute Resolution (in lieu of 74A-3, 74A-4, 74A-8, 74A-9, 74A-36, 74A-44, 74A-45 and 74A-46) Adopted as Amended. See 74A-3.

• **RESOLUTION 74A-10**

Regionalization of Health Services
Donald N. Fitch, MD, Delta-Schoolcraft County

House Action: Substitute Resolution (in lieu of 74A-10 and 74A-34) Adopted

Whereas, the Regionalization of Health Services involves the carefully planned and appropriate organization of health care delivery into geographic regions for specific medical situations (neonatal, neonatology, acute trauma care, etc.) to allow increased availability of advanced medical technology to be economically feasible, and

Whereas, Regional Medical Programming initially is a national health policy currently in various stages of implementation on a state level, and

Whereas, Regionalization cannot reach the goals for which it was devised without the cooperation and input at all levels by the local medical societies and particularly the private practicing physicians, and

Whereas, thus far regionalization has developed with limited input, therefore be it

RESOLVED: That the Michigan State Medical Society support the concept of appropriate regionalization of medical services if there is involvement of the private physician and local medical societies, and be it further

RESOLVED: That this resolution be distributed to the Governor, the Department of Social Services, and the Comprehensive Health Planning Boards throughout the State.

• **RESOLUTION 74A-11**

Regional Reimbursement Discrimination
Donald N. Fitch, MD, Delta-Schoolcraft County

House Action: Substitute Resolution (in lieu of 74A-11) Adopted

Whereas, third parties and particularly the various levels of government are becoming increasingly involved in the reimbursement for medical services, and

Whereas, it has been well documented by the Michigan State Medical Society Bureau of Ecomonic Information that the cost of practicing medicine is not significantly different in different regions of the State, and

Whereas, the cost of living is no longer at a variance in different regions of the State, and

Whereas, all consumer payments be they as premiums or tax dollars or whatever are levied at nearly the same rate throughout, and the level of medical care that evolves, either as manpower availability, or as physical facilities is a direct reflection of the level of reimbursement as compared with the level in different areas, thus creating an inequity for some recipients of health care, and

Whereas, the 1973 House of Delegates to MSMS concurred in the concept of usual, customary and reasonable fee without regionalization, and

Whereas, HR 13958, a bill before the 93rd Congress asks to amend Title XVIII of the Social Security Act to provide that the determination of the "reasonable charge" for services furnished in any state by a physician or other person under the supplementary medical insurance program shall be made on the basis of the prevailing and customary charges for similar services throughout such state rather than on the basis of the corresponding charges in a particular locality, therefore be it

RESOLVED: That the House of Delegates of the Michigan State Medical Society emphatically supports HR 13958 of the 93rd Congress and requests that MSMS staff distribute copies of this resolution to the appropriate representative, such as the members of the House Ways and Means Committee, Michigan representatives and senators, and Representative Froehlich, the sponsor of HR 13958.

• **RESOLUTION 74A-12**

Compensation for the President of Michigan State Medical Society
Kornelius Van Goor, MD, Kent County

House Action: No Action

Whereas, the responsibilities of the President of the Michigan State Medical Society are becoming more and more demanding, and

Whereas, these responsibilities require increasingly more time and effort on the part of the President, and

Whereas, this increase of time spent as an officer of this Society necessitates a corresponding decrease in time spent in private practice, and

Whereas, such time loss in private practice results in considerable loss of income, therefore be it

RESOLVED: That an ad hoc committee be formed from the delegates to the Michigan State Medical Society to study in depth and detail the possibility of remuneration for serving as President of Michigan State Medical Society, and be it further

RESOLVED: That such committee also explore the possibilities of remuneration for services of other office bearers, and be it further

RESOLVED: That such committee make its report and recommendations at the next annual meeting.

• **RESOLUTION 74A-13**

Standardizing PSRO and Reimbursement
Charles E. Conaway, MD, Lapeer County

House Action: No Action

Whereas, the State of Michigan is divided into geographic and population areas by Blue Cross/Blue Shield, Medicare, and Medicaid, and

Whereas, each of these areas have variable fee schedules, and

Whereas, PSRO groups now being formed are not along these same geographical — population guidelines,

therefore be it

RESOLVED: That all medical organizations in a PSRO group be treated equally as to payment and reimbursement for medical services rendered, and be it further

RESOLVED: That the State Medical Society institute whatever appropriate action necessary to accomplish this.

• **RESOLUTION 74A-14**

PSRO
Thomas J. Setter, MD, Macomb County

House Action: Disapproved

Whereas, PSRO is now the law of the land and there is little chance for repeal, and

Whereas, law properly implemented by physicians will prove for the first time the high level of excellence of physicians, and

Whereas, if the physicians do not support PSRO, the medical schools or public health will take over, and therefore be it

RESOLVED: That MSMS totally support PSRO.

• **RESOLUTION 74A-15**

Elimination of Contingency Fee
Henry T. Forsyth, MD, Shiawassee County

House Action: Adopted as Amended

Whereas, many diagnostic tests are ordered defensively by physicians in recognition of the threat of malpractice action, and

Whereas, the high cost of medical practice insurance and defensive medical tests must be passed on to the patient by increased physician fees for services, and

Whereas, the increasing threat of malpractice action against physicians is encouraged by a system of civil justice which allows the acceptance of a liability case by a lawyer on a contingency fee basis, therefore be it

RESOLVED: That the Michigan State Medical Society deplores contingency fee compensation of members of the Bar in medical malpractice action and encourages the legal community to accept a "reasonable and customary" fee for services rendered, and be it further

RESOLVED: That the Liaison Committee with the State Bar of Michigan be encouraged to seek their aid in the resolution of this problem, and be it further

RESOLVED: That the MSMS instruct the legislative committee of The Council to initiate legislation that will abolish the contingency fee system by introduction of a bill in the legislature of the State of Michigan.

• **RESOLUTION 74A-16**

Informed Consent
Peter A. Duhamel, MD, Oakland County

House Action: Adopted as Amended

Whereas, consent forms for operations and/or treatment continue to be an important consideration in medical practice today, and

Whereas, present variety of forms give questionable legal coverage and have become increasingly confusing and alarming to both patient and physician, and

Whereas, the need for a simple yet comprehensive form would be desirable, therefore be it

RESOLVED: that the Michigan State Medical Society appoint a committee with its legal counsel to study the problem and produce a simple form of consent.

• **RESOLUTION 74A-17**

Foreign Doctors
Jaime V. Aragones, MD, Oakland County

House Action: Adopted as Amended

Whereas, a growing population of unlicensed foreign medical doctors presently reside in the state of Michigan, and

Whereas, inability to pass present licensure examinations have forced them to accept paramedical positions such as morticians, scrub technicians, laboratory technicians, drug detail men, etc., and

Whereas, the state of Michigan stands to benefit from this additional physician manpower if they were to qualify themselves and continue to reside in this state, therefore be it

RESOLVED: That the Chairman of The Council of the Michigan State Medical Society appoint a committee to survey the existing population of these physicians, and be it further

RESOLVED: That this Committee arrange with suitable institutions a program to improve the proficiency of these physicians in English and the basic sciences so that they are better prepared to undertake examination for licensure, and be it further

RESOLVED: That an advisory committee be formed to assist these physicians in placing themselves for further training and/or locating in areas in need of doctors.

• **RESOLUTION 74A-18**

The State of Michigan as a PSRO Unit
Richard C. Deming, MD, Jackson County

House Action: No Action

Whereas, MSMS has attempted to obtain approval of the State of Michigan as a PSRO unit, and

Whereas, there has been great vacillation by the Secretary of HEW in establishing divisional areas of PSRO in the State of Michigan and elsewhere, and

Whereas, HEW has stated they will not negotiate or deal with the State Medical Society and that they have, in fact, been forced to work through the only established representatives of the physicians of Michigan, the MSMS, and

Whereas, division of the State of Michigan into numerous PSRO areas would leave these small PSRO areas without counsel or cohesion within the state, and

Whereas, small units without support of its peers throughout the state and without leadership from its mother society, the MSMS, said small units would be controlled at the whim of the Secretary of HEW, and

Whereas, the division of the state into small units would work to the detriment of the patients and physicians of the State of Michigan, and

Whereas, several states have been designated as PSRO units demonstrating feasibility of such a denomination, and therefore be it

RESOLVED: That the House of Delegates of MSMS advise the Secretary of HEW that the MSMS and its members will participate in PSRO only as a State of Michigan unit and will refuse to part in any other division.

• **RESOLUTION 74A-19**

MSMS Support to Repeal PSRO Provisions of the Social Security Act
Richard C. Deming, MD, Jackson County

House Action: Disapproved

Whereas, House Bill 9375 has been introduced into the House of Representatives by Representative Rarick on July 13, 1973 to repeal the repressive PSRO provisions of the Social Security Act, and

Whereas, the House of Delegates to the American Medical Association have stated the repeal of the PSRO Amendment would be to the benefit of the citizens of the United States and the physicians, and

Whereas, the House of Delegates of the MSMS have previously recommended repeal of the PSRO amendment, and

Whereas, several State Medical Societies have already gone on record to repeal the PSRO Amendment, and

Whereas, many members of the Congress of the United States at the last meeting of the House of Delegates to the AMA have signified their disapproval of these PSRO Amendments, and therefore be it

RESOLVED: That the MSMS House of Delegates convey to its membership and its representatives to the AMA and to the State of Michigan representatives and Senators, to the Congress of the United States, its opposition to the PSRO Amendments and recommend approval of House Bill HR 9375 (the Rarick Bill) to repeal those amendments to the Social Security Act known as the PSRO Amendments.

• **RESOLUTION 74A-20**

Reaffirmation of Resolution 73A-2 (PSRO)
Francis A. Martin, MD, Oakland County

House Action: Adopted

Whereas, it is appropriate, in the light of current knowledge and developments, for the Michigan State Medical Society, to restate its opinion and stance on the PSRO amendment of PL 92-603, therefore be it

RESOLVED: That Resolution 73A-2, as adopted by the House of Delegates, be reaffirmed in its entirety, and be it further

RESOLVED: That the Michigan delegates to the American Medical Association be urged to carry out this mandate of the Michigan physicians at future meetings of the House of Delegates of the American Medical Association.

RESOLUTION 73A-2

Repeal of PSRO Amendment
Clark B. Smith, MD, Hillsdale County

House Action: Substitute Resolution (in lieu of 73A-2, 73A-17, 73A-18 and 73A-19) Adopted as Amended

Whereas, the PSRO Section of P.L. 92-603, October 30, 1972, is an existing statute, and

Whereas, this statute infringes upon:

1. Physician-patient relationship
2. Confidentiality
3. Freedom of choice of physician
4. Professional judgements by substituting computerized standards, and

Whereas, the statute intends quality medical services, it does, in fact, mainly address itself to cost-control, and

Whereas, the Secretary of HEW is empowered to designate PSROs without relation to organized medicine, therefore, be it

RESOLVED: That the Michigan State Medical Society work for the repeal of the PSRO Section of P.L. 92-603 through all methods available, and be it further

RESOLVED: That the Michigan State Medical Society through—The Council and the Ad Hoc Committee to Coordinate PSRO Activity in Michigan, continue to monitor developments in this area, and if the Bennett Amendment is not repealed, actively seek to amend its provisions to protect both the public and the medical profession and be it further

RESOLVED: That the Michigan State Medical Society develop viable alternative plans for the review of the delivery of quality medical services at reasonable costs and be it further

RESOLVED: That any implementation of PSRO be a decision of the House of Delegates of the Michigan State Medical Society, and be it further

RESOLVED: That this resolution be distributed to:

1. The House of Delegates of the American Medical Association by the Michigan Delegation to the American Medical Association.
2. To each State Medical Society.
3. To every member of the Michigan State Medical Society and to Michigan's two Senators and members of the House of Representatives.

• **RESOLUTION 74A-21**

PSRO
F. Alan Kennedy, MD, Berrien County

House Action: Substitute Resolution (in lieu of 74A-7, 74A-21 and 74A-26) Adopted. See 74A-7

• **RESOLUTION 74A-22**

Combining of Departments of Michigan State University College of Human Medicine and the College of Osteopathic Medicine
Richard L. Rapport, MD, Genesee County

House Action: Adopted as Amended

Whereas, the combining of the various departments of the Michigan State University College of Human Medicine and the College of Osteopathic Medicine is recognized as being desirable from an economic standpoint, and

Whereas, it has been mandated by the Michigan State Legislature that physical resources and facilities must be shared by the two disciplines, therefore be it

RESOLVED: That the Michigan State Medical Society endorses the combining of departments of the College of Human Medicine and the College of Osteopathic Medicine at Michigan State University wherever feasible.

• **RESOLUTION 74A-23**

Athletic Examinations for Junior & Senior High School Students
John Quin, Jr., MD, Genesee County

House Action: Disapproved

Whereas, the need for periodic health examinations of students involved in interscholastic athletic activities is recognized, and

Whereas, the present program of requiring annual examinations of these athletes results in redundant examinations of an unusually healthy portion of our population, and

Whereas, annual athletic examinations result in unwarranted cost to the whole community, and

Whereas, the present policy results in an unreasonable hardship for many of the prospective student athletes, therefore be it

RESOLVED: That only one physical examination be required at Junior High School level and one physical examination at Senior High School level for participation in interscholastic athletics, unless serious injury or illness occurs, and be it further

RESOLVED: That the Michigan State Medical Society recommend to the Michigan High School Athletic Association that this policy be adopted on a statewide level.

• **RESOLUTION 74A-24**

Notice of Suspension of a Medical Doctor's License to Practice
Richard J. McMurray, MD, Genesee County

House Action: Adopted as Amended

Whereas, suspension of a medical doctor's license is of primary importance and interest to the component medical society in the area in which he practices, and

Whereas, the component medical society bears a responsibility to relay this information to local hospital medical staffs and other concerned health service providers, and

Whereas, awareness of such serious disciplinary action is essential to protect the quality of medical care services and the image of the medical profession, and

Whereas, no provisions now exist whereby component medical societies are notified of such action, therefore be it

RESOLVED: That the Michigan State Medical Practice Board, through the Attorney General's Office, be respectfully requested to notify Michigan State Medical Society, and through it the component medical societies of any such actions at the earliest possible opportunity.

• **RESOLUTION 74A-25**

Chiropractic Education
Thomas C. Payne, MD, Ingham County

House Action: Adopted

Whereas, the 1973 spring House of Delegates adopted a resolution to set in motion a series of MSMS educational efforts re chiropractic, and

Whereas, the MSMS Committee on Public Relations has adopted chiropractic education as one of its major projects for 1974, and

Whereas, the MSMS Council has appointed a special Task Force on Chiropractic to work within the framework of the Committee on Public Relations, and

Whereas, many components have appointed component representatives, as requested, to the Task Force and two meetings have been held already of the Task Force, and

Whereas, the Committee on Public Relations and the Task Force have provided MD speakers, on a pilot basis, to three component societies with reported good results, therefore be it

RESOLVED: That the MSMS Committee on Public Relations and the special Task Force on Chiropractic expand its speakers bureau for component societies, and be it further

RESOLVED: That component societies (and Michigan specialty societies, too) be requested to schedule a program about chiropractic at one of its fall, 1974 or spring, 1975 membership meetings as an essential segment of the MSMS effort to inform doctors of medicine (their spouses and medical assistants) about the weaknesses of chiropractic.

• **RESOLUTION 74A-26**

Statewide PSRO Support Center for Michigan
Leland E. Holly, II, MD, Muskegon County

House Action: Substitute Resolution (in lieu of 74A-7, 74A-21, and 74A-26) Adopted. See 74A-7

• **RESOLUTION 74A-27**

Telephone Technique Workshops for Medical Assistants
Thomas C. Payne, MD, Ingham County

House Action: Adopted as Amended

Whereas, competent and courteous medical assistants are a decided asset to the daily functioning of a doctor's office, and

Whereas, there exist few practical, in-service training programs designed to sharpen the vital communications and human relations skills required daily of the office medical assistant, and

Whereas, the MSMS Communications Department and the American Association of Medical Assistants — State of Michigan have developed a program and script on telephone techniques suitable for workshop use, and

Whereas, two pilot workshops sponsored by MSMS

and the Ingham County Medical Society for Ingham medical assistants attracted overflow audiences, therefore be it

RESOLVED: That each MSMS component society be urged to periodically conduct workshops on telephone techniques for medical assistants.

• **RESOLUTION 74A-28**

Diagnosis for Screening Procedures
Raymond J. Barrett, MD, Wayne County

House Action: Substitute Resolution (in lieu of 74A-28) Adopted

Whereas, third-party carriers require a diagnosis for payment of laboratory and X-ray procedures, and

Whereas, good medical practice may require diagnostic screening examinations to exclude the possibility of additional disease, therefore be it

RESOLVED: That excluding diagnosis (e.g., to exclude diabetes) will be justification for ordering such screening procedures, and be it further

RESOLVED: That third-party carriers be urged to provide payment for these necessary examinations.

• **RESOLUTION 74A-29**

Study of Arbitration in Malpractice Cases
Kenneth J. Ray, MD, Wayne County

House Action: Adopted as Amended

Whereas, there has been a marked increase in malpractice cases against physicians, many leading to court trials before lay juries, and

Whereas, lay jurors, even the most intelligent, cannot understand the technical problems involved in most malpractice cases against physicians, and

Whereas, some better method of resolution of cases of malpractice against physicians should be devised, therefore be it

RESOLVED: That the House of Delegates of Michigan State Medical Society direct that The Council of Michigan State Medical Society appoint a study committee to investigate arbitration procedures in other states and Canada; to discuss in detail with malpractice insurance carriers and relevant bar associations all features of arbitration of malpractice cases; and to independently determine if arbitration of malpractice cases would be of value to the medical profession of Michigan, and be it further

RESOLVED: That said committee report its findings and recommendations to this House of Delegates not later than the spring session of 1975.

• **RESOLUTION 74A-30**

Social Perspectives of Medicine
Ned I. Chalat, MD, Wayne County

House Action: No Action

Whereas, a significant percentage of patients have difficulties from poor education in addition to the social and environmental conditions, and

Whereas, current concepts and definitions of health care extend the scope of medicine beyond the care of the sick, and

Whereas, it is important to have better understanding of man's behavior under stress, and

Whereas, this study of individual psyche leads directly to new areas, therefore be it

RESOLVED: That the Michigan State Medical Society establish a committee entitled "Social Perspectives of Medicine," charged with promoting interest in and improvement of the quality of life within our community.

• **RESOLUTION 74A-31**

Identification of Physician
Charles E. Darling, MD, Wayne County

House Action: Substitute Resolution (in lieu of 74A-1, 74A-2 and 74A-31) Adopted. See 74A-1.

• **RESOLUTION 74A-32**

Discrimination Against Alcoholics
Ned I. Chalat, MD, Wayne County

House Action: Substitute Resolution (in lieu of 74A-32) Adopted

Whereas, all carriers offering health insurance will be statutorally required to include the treatment of alcoholics in their benefits as of July 1, 1974, and

Whereas, hospitals and all other facilities are urged to accept alcoholics as all other patients on the basis of medical needs, therefore be it

RESOLVED: That the Michigan State Medical Society seek the development of rehabilitation programs (for alcoholism) through referral by The Council to an appropriate committee for further study.

• **RESOLUTION 74A-33**

Advertising by Physicians
Charles E. Darling, MD, Wayne County

House Action: Adopted as Amended

Whereas, there is much current controversy related to advertising by physicians, prepaid health services, and free-standing abortion facilities, and

Whereas, the opportunists appear to split the professional fees for medical services, and

Whereas, confusion may develop concerning ethical principles related to advertising these medical services, therefore be it

RESOLVED: That the Michigan State Medical Society and its component county societies reemphasize and insist upon the ethical practice of medicine, that physicians may not advertise their services individually or collectively, and be it further

RESOLVED: That continued publicity concerning ethical practice be a constant theme in our appropriate state and county publications.

• **RESOLUTION 74A-34**

Emergency Medical Service
Paul Connolly, MD, Wayne County

House Action: Substitute Resolution (in lieu of 74A-10 and 74A-34) Adopted. See 74A-10

• **RESOLUTION 74A-35**

Hand Gun Control
Thomas Flake, MD, Wayne County

House Action: Adopted as Amended

Whereas, the House of Delegates of the Michigan State Medical Society recommended in September, 1971, strong control be placed on the availability of hand guns and that legislation to this end be supported, and

Whereas, the American Medical Association House of Delegates in June, 1972, expressed its strong abhorrence to the use of firearms or any weapon in the commission of a crime and urged the strong enforcement of strict penalties for such use, and

Whereas, homicide by means of firearms has increased to serious proportions, therefore be it

RESOLVED: That the Michigan State Medical Society House of Delegates reaffirm its 1971 action for strong control of the availability of hand guns and urge strong enforcement of existing gun laws.

• **RESOLUTION 74A-36**

Participation Agreements
Ned I. Chalat, MD, Wayne County

House Action: Substitute Resolution (in lieu of 74A-3, 74A-4, 74A-8, 74A-9, 74A-36, 74A-44, 74A-45 and 74A-46) Adopted as Amended. See 74A-3.

• **RESOLUTION 74A-37**

Peer Review Mechanism
Homer M. Smathers, MD, Wayne County

House Action: Disapproved

Whereas, indications are that Peer Review requirements will not be repealed but expanded as government programs increase in number and scope, and

Whereas, the medical profession has the opportunity and obligation now to establish peer review programs for their area with norms and standards of care based on the practice in that locality or after January 1, 1976 to accept those designated by the Secretary of HEW, and

Whereas, the creation of a peer review program is a complex and difficult assignment which will require the full participation and support of all physicians in the respective areas, therefore be it

RESOLVED: That Michigan State Medical Society, each component medical society and all members direct their efforts to the establishment of functional peer review programs in their respective areas.

• **RESOLUTION 74A-38**

Provisional Membership
John W. Moses, MD, Wayne County

House Action: Adopted. (The House approved a recommendation from the reference committee that development of appropriate bylaws amendments be deferred until the new rules and regulations regarding restricted licenses are clearly spelled out by the Medical Practice Board)

Whereas, the revised Michigan Medical Practice Act provides for limited licenses for physicians, and

Whereas, physicians with limited licenses should be encouraged to maintain their membership or to join the component and State Medical Society during his period of probation, and

Whereas, active membership in the Michigan State Medical Society should be restricted to fully licensed physicians, therefore be it

RESOLVED: That the Committee on Constitution & Bylaws be instructed to draft a new membership classification for physicians with limited licenses.

• **RESOLUTION 74A-39**

Gasoline for Health Care
Gerald Mandell, MD, Wayne County

House Action: Substitute Resolution (in lieu of 74A-39) Adopted

RESOLVED: That The Council of the Michigan State Medical Society be authorized to request of the Governor and the Legislature, when necessary, that providers of health care have necessary allocations of gasoline during the periods of shortage.

• **RESOLUTION 74A-40**

PSROs & National Health Insurance
Richard Rasmussen, MD, Kent County

House Action: Disapproved

Whereas, the Administration's bill and the Kennedy-Mills bill to establish National Health Insurance have been introduced, and

Whereas, political observers anticipate that one or a combination of these bills will be the basis for enactment of a National Health Insurance law by 1976 at the latest, and

Whereas, both proposals provide for PSROs to monitor the expenditure of tax dollars that will fund National Health Insurance, therefore be it

RESOLVED: That MSMS and its component societies take positive steps now to influence the development of PSROs in Michigan to negotiate conditional contracts that will assure (1) locally determined medical care criteria and (2) physician control of the review process.

• **RESOLUTION 74A-41**

Use of National Television
Robert E. Paxton, MD, Newaygo County

House Action: Adopted as Amended

Whereas, science and medicine grow and prosper only in an arena of freedom, and

Whereas, American medicine has achieved worldwide leadership in quality medical care because of such personal freedom, and

Whereas, such freedom is threatened even more by an ever-burgeoning governmental bureaucracy, and

Whereas, many critics of the medical profession continue to criticize physicians and the medical societies unjustly for the rising costs of medical care, and

Whereas, the TV networks and TV stations understandably will not carry any medical society message dealing with social and economic issues as free, public service announcements, therefore be it

RESOLVED: That the MSMS delegation to the AMA introduce a resolution at the 1974 June AMA House of Delegates which would instruct the AMA staff to work with appropriate advice from the AMA Board of Trustees, to develop messages presenting the physicians' views to be placed with major TV stations as paid announcements; and would urge each member of the AMA

to voluntarily contribute to a special AMA fund for such pro-AMA messages about current medical and health care issues.

• **RESOLUTION 74A-42**

Catastrophic Health Insurance
Jack M. Stack, MD, Gratiot County

House Action: Adopted as Amended

Whereas, over the next few years there will continue a great national debate on the question of comprehensive health insurance for all, and

Whereas, most American families have personal health insurance and are able to finance a major portion of their own health care, and

Whereas, there are catastrophic illnesses of such magnitude that no person or family can sustain the cost of care without financial ruin, and

Whereas, no family should be forced to lose all personal assets through catastrophic illness, and

Whereas, there is a growing awareness among the public of the need for catastrophic health insurance, and

Whereas, an element in the debate for comprehensive health insurance agreed upon by nearly all is the overriding need for catastrophic health insurance, and

Whereas, Michigan could lead the nation in the development of a catastrophic health insurance plan, and

Whereas, any plan which Michigan developed could serve as a model for a national plan and could phase into a national plan, therefore be it

RESOLVED: That the Michigan State Medical Society support the development of a statewide comprehensive catastrophic health insurance plan, and work with government, business, consumers and leaders in the health industry to create and implement such a plan.

• **RESOLUTION 74A-43**

Guideline for Hospital Constitution & Bylaws
Robert Jardinico, MD, Saginaw County

House Action: Adopted as Amended

Whereas, hospitals and other health care institutions are recognizing their responsibility as governing boards, and

Whereas, these institutions have funds and access to legal counsel to represent them, and

Whereas, the practicing physician has neither the funds nor legal expertise to protect him in the discharge of his responsibility to his patients, therefore be it

RESOLVED: That MSMS make available its legal services to assist a medical staff in informing the membership of its rights and privileges.

• **RESOLUTION 74A-44**

Customary and Prevailing Fees
Orville W. Oughtred, MD, Macomb County

House Action: Substitute Resolution (in lieu of 74A-3, 74A-4, 74A-8, 74A-9, 74A-36, 74A-44, 74A-45 and 74A-46) Adopted as Amended. See 74A-3.

• **RESOLUTION 74A-45**

Action on Profile Submissions
Orville W. Oughtred, MD, Macomb County

House Action: Substitute Resolution (in lieu of 74A-3, 74A-4, 74A-8, 74A-9, 74A-36, 74A-44, 74A-45 and 74A-46) Adopted as Amended. See 74A-3.

• **RESOLUTION 74A-46**

Customary & Prevailing Medical Fees Applicable to Profile Level
Orville W. Oughtred, MD, Macomb County

House Action: Substitute Resolution (in lieu of 74A-3, 74A-4, 74A-8, 74A-9, 74A-36, 74A-44, 74A-45 and 74A-46) Adopted as Amended. See 74A-3.

• **RESOLUTION 74A-47**

Mandatory Membership in American Medical Association
Orville W. Oughtred, MD, Macomb County

House Action: Adopted as Amended

Whereas, local and state societies are supporting the AMA in its efforts in solving the complexities of delivery of health care, therefore be it

RESOLVED: That MSMS urge combined membership in the county society, the MSMS and the AMA so that medicine can present a strong and united front.

• **RESOLUTION 74A-48**

Activities of Peer Review Foundations and Corporations
Richard Rapport, MD, Genesee County

House Action: Adopted

Whereas, the Michigan State Medical Society has resolved that peer review activities within the State of Michigan should not commence without specific direction from the House of Delegates, and

Whereas, proposed and existing corporations and foundations are in various stages of development directed toward proceeding with such activities, and

Whereas, the membership and directors of such corporations and foundations embrace osteopathic physicians, dentists and other providers, not of the MSMS, and

Whereas, such corporations and foundations can legally proceed without the approval of MSMS, therefore be it

RESOLVED: That the House of Delegates of MSMS rescind its action directed toward restraining such (peer review) corporations and foundations and their directors and membership from their activities.

• **RESOLUTION 74A-49**

Activities of the Ad Hoc Committee on Peer Review Systems

Donald K. Crandall, MD, Muskegon

House Action: Adopted

Whereas, before there can be state approval or disapproval of PSRO implementation there must be negotiations, investigations and pilot programs with the information and experience gained therefrom transmitted to the House of Delegates; therefore be it

RESOLVED: That the Ad Hoc Committee on Peer Review Systems be instructed to carry on and assist in such activities including a report at the next House of Delegates meeting.

SPECIAL MEMBERSHIPS

The Reference Committee on Special Memberships, Robert J. Fisher, MD, Chairman, recommended approval of the following special memberships as recommended by the component medical societies and certified by the secretary of MSMS in accordance with the Bylaws:

RETIRED MEMBERSHIPS — members who have maintained membership for 10 years in the component medical society and retired from active practice.

Calhoun County—Arnold A. Albright, MD; Philip M. Henderson, MD.
Genesee County—Ralph E. Dawson, MD.
Jackson County—Saul Appel, MD; H. B. McLauthlin, MD.
Kalamazoo County—Flora E. Scherer, MD; James P. Curran, MD.
Macomb County—John G. Barker, MD.
Mecosta County—James L. Tyson, MD.
Northern Michigan—William S. Conway, MD.
Oakland County—William J. Hopkins, MD.
Saginaw County—Allen K. Cameron, MD; Francis L. Markey, MD; Norman Westlund, MD.
St. Clair County—Robert E. Rowe, MD.
Washtenaw County—Jerome W. Conn, MD, Isadore Lampe, MD.
Wayne County—Elvis S. Alford, MD; Thelma M. Campbell, MD; Herbert H. Cohen, MD; Adolf W. Lowe, MD; John P. Ottaway, MD.

LIFE MEMBERSHIP—member who has maintained membership for 25 years in a constituent state society of the American Medical Association with five years in Michigan and has either obtained the age of 70 or been in practice 50 years.

Bay County—Harold H. Heuser, MD.
Calhoun County—Harvey C. Hansen, MD.
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Huron County—Charles W. Oakes, Jr., MD.
Jackson County—Frank Van Schoick, MD.
Kent County—Jack Hoogerhyde, MD; L. Paul Ralph, MD; Raymond E. Sculley, MD; Stuart Bergsma, MD.
Macomb County—Arthur M. Rothman, MD.
Mason County—Gladys J. Kleinschmidt, MD.
Monroe County—A. Esther Johnson, MD.
Wayne County—Richard H. Baugh, MD; Benjamin Brand, MD; Harry S. Burstein, MD; Henry A. Dunlap, MD; Wallace M. Foster, MD; Elmer A. Goerke, MD; Louis M. Harley, MD; Lyle E. Heavner, MD; Manuel H. Hendelman, MD; H. Horne Huggins, MD; William A. Irwin, MD; James M. Kennary, MD; Valentine L. Koran, MD; Cecil W. Lepard, MD; Ralph C. Magnell, MD; Alex Olen, MD; Emil F. Rupprecht, MD; Harry H. Sand, MD; Eugene M. Shafarman, MD; Lewis C. Wassermann, MD; Harwood G. Watson, MD; Maurice B. Weiner, MD; Jacob Weinstein, MD; Leston S. Whitehead, MD.

THE HOUSE adopted the report of the Reference Committee.

PRESENTATIONS AND AWARDS

EMPLOYEE AWARDS

Secretary Kenneth H. Johnson, MD, presented the following employee awards as previously authorized by the House of Delegates:

Maynard Hoover—10 years of service
Herbert Auer—15 years of service

REFERENCE COMMITTEES—1974 ANNUAL SESSION

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William Middleton, SAMA, Univ. of Mich.
Harry Tarpinian, MD, Wayne

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Joseph L. Posch, MD, Wayne

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Robert J. Toteff, MD, Saginaw
S. A. Yannitelli, MD, Calhoun
John Wood, MD, Isabella-Clare

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Frank B. Walker, MD, Wayne

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John R. Ylvisaker, MD, Oakland

1974 MSMS HOUSE OF DELEGATES RECORD OF ATTENDANCE

	Meeting		
OFFICERS:	1st	2nd	3rd
Speaker:			
Vernon V. Bass, MD	x	x	x
Vice Speaker:			
James D. Fryfogle, MD	x	x	x
Secretary:			
Kenneth H. Johnson, MD	x	x	x
DELEGATES & ALTERNATES:			
ALLEGAN			
Richard L. Plagenhoef, MD	x	x	—
ALPENA-ALCONA-PRESQUE ISLE			
F. C. O'Dell, MD	x	x	x
BARRY			
Larry L. Blair, MD	x	x	—
BAY-ARENAC-IOSCO			
John W. Grigg, MD	x	—	—
Walter L. Howland, MD	x	x	x
BERRIEN			
F. Alan Kennedy, MD	x	x	x
Fred H. Lindenfeld, MD	x	x	x
BRANCH			
Henry C. Gomley, MD Malcolm D. Steider, MD	x	x	x
CALHOUN			
S. A. Yannitelli, MD	x	x	x
Walter B. Long, MD	x	x	x
William D. Walter, MD	x	x	x
CASS			
Not Represented			
CHIPPEWA-MACKINAC			
Donald D. Finlayson, MD	x	x	x
CLINTON			
James M. Grost, MD	x	x	—
DELTA-SCHOOLCRAFT			
Donald N. Fitch, MD	x	x	x
DICKINSON-IRON			
Paul R. Trump, MD	x	x	x
EATON			
Eber B. Sherman, MD	x	x	—
GENESEE			
John C. Benson, Md	x	x	—
John W. MacKenzie, MD	—	—	x
Charles A. Thompson, MD	x	x	—
Carl H. Mangelsdorf, MD	—	—	x
Richard L. Rapport, MD	x	x	x

Lewis E. Simoni, MD	x	x	x
Richard J. McMurray, MD	x	x	x
John Quin, Jr., MD	x	x	x
Joseph T. Batdorf, MD	—	—	—
John W. MacKenzie, MD	—	x	—
GOGEBIC			
Not Represented			
GRAND TRAVERSE-LEELANAU-BENZIE			
Arthur F. Dundon, MD	x	x	x
Kenneth H. Musson, MD	x	x	x
GRATIOT			
Not Represented			
HILLSDALE			
Not Represented			
HOUGHTON-BARAGA-KEWEENAW			
Kenneth E. Rowe, MD	x	x	x
HURON			
K. B. Herrington, MD	x	x	x
INGHAM			
Thomas C. Blair, MD	x	—	—
D. Bonta Hiscoe, MD	x	x	x
Harry C. George, MD			
Gordon R. Harrod, MD	x	x	x
Thomas C. Payne, MD	x	x	x
George D. Stilwill, MD	x	x	x
David Siegel, MD	x	x	x
IONIA-MONTCALM			
Robert E. Rice, MD	x	x	x
ISABELLA-CLARE			
John M. Wood, MD	x	—	—
Martin M. Nosan, MD	—	x	—
JACKSON			
Richard C. Deming, MD	x	x	x
Henry A. Kallet, MD	x	x	x
KALAMAZOO			
Almon L. Schut, MD	x	—	—
Fred L. Wedeking, MD	x	x	—
Robert C. Kettunen, MD	x	—	—
Harold R. Reames, MD	x	x	x
Thomas R. Berglund, MD	x	x	—
KENT			
Fred C. Brace, MD	x	x	x
Frederick S. Gillett, MD	x	x	x
William Haeck, MD	x	x	x
Joseph R. Lentini, MD	x	x	x
Richard A. Rasmussen, MD	x	x	x
Jack G. Lukens, MD	x	x	x
Kornelius Van Goor, MD	x	x	x
William E. Kincaid, MD	x	x	x
Harvey M. Andre, MD	x	x	x
Robert D. Burton, MD	x	x	x
LAPEER			
Charles E. Conaway, MD	x	x	x
LENAWEE			
Richard H. Gascoigne, MD	x	x	x
LIVINGSTON			
Edwin S. Woodworth, MD	x	—	—
LUCE			
Not Represented			
MACOMB			
Joseph J. LaHood, MD	x	x	x
Earl G. Moehn, MD	x	x	x
Orville W. Oughtred, MD	x	x	x
Thomas J. Setter, MD			
Jule J. Merritt, MD	x	x	—
William C. Wyte, MD	x	x	x
MANISTEE			
Vickers C. Hansen, MD	x	x	x
MARQUETTE-ALGER			
George M. Wilson, Jr., MD	x	x	x
MASON			
William F. Sutter, MD	x	x	x
MECOSTA-OSCEOLA-LAKE			
Jerome A. Conrad, MD	x	x	x
MENOMINEE			
William S. Jones, Jr., MD	x	x	—
MIDLAND			
Charles H. Willison, MD	x	x	x
MONROE			
S. Newton Kelso, Jr., MD	x	x	x
MUSKEGON			
Richard T. Allen, MD	x	x	x
Donald K. Crandall, MD	x	x	x
Robert C. Packer, MD	x	x	x
NEWAYGO			
Robert E. Paxton, MD	x	x	x
NORTH CENTRAL			
Charles L. Oppy, MD	x	x	x
NORTHERN MICHIGAN			
Russell F. LaBeau, MD	x	x	—
OAKLAND			
Worth W. Henderson, MD			
Nanette J. Jagnow, MD	x	x	x
John H. McLaughlin, MD	x	x	x
James R. Quinn, MD	x	x	—
Peter A. Duhamel, MD	x	x	—
Edward E. Elder, Jr., MD	x	x	x
E. William Bauer, MD			
Paul D. Croissant, MD	x	—	—
James A. Read, MD	x	x	x
Fred W. Bryant, MD	x	x	x
Kenneth L. Urwiller, MD	x	x	x
Keith M. Holmes, MD	x	—	—
Francis A. Martin, MD	x	x	x
John B. Bryan, MD	x	x	x
Jaime V. Aragones, MD	x	x	x
Richard E. Straith, MD			
Gerald F. Conway, MD	x	x	x
OCEANA			
John J. Vrbanac, MD	x	x	—
ONTONAGON			
Not Represented			
OTTAWA			
Alvin Bonzelaar, MD	x	x	x

Peter J. Verkaik, MD	x	x	x
SAGINAW			
Jack L. Barry, MD	x	x	—
Vernon V. Bass, MD			
Robert Jardinico, MD	x	—	—
Roy J. Gerard, MD	x	x	—
Robert J. Toteff, MD	x	x	x
ST. CLAIR			
Daniel J. Wilhelm, MD	x	x	x
James J. Snider, MD	x	x	x
ST. JOSEPH			
Robert H. Evans, MD	x	x	x
SANILAC			
Keate T. McGunegle, MD	x	x	x
SHIAWASSEE			
Henry T. Forsyth, MD	x	x	x
TUSCOLA			
Not Represented			
VAN BUREN			
David J. Millard, MD	x	x	x
WASHTENAW			
Dean P. Carron, MD	x	x	x
George W. Morley, MD	x	x	x
John W. Henderson, MD			
Roger W. Postmus, MD	x	—	—
Beverly C. Payne, MD	x	x	x
Lyle D. Elliott, MD	x	x	x
Harold F. Falls, MD	x	x	—
Robert J. Fisher, MD	x	x	x
George H. Koepke, MD	x	x	x
Henry G. Scovill, MD			
Fred E. Patterson, MD	x	—	—
WAYNE			
Ned I. Chalat, MD	x	x	—
Charles E. Darling, MD	x	x	x
Arthur A. Ulmer, MD	x	x	x
Homer M. Smathers, MD	x	x	x
Sidney E. Chapin, MD	x	x	x
Sidney Adler, MD	x	—	—
James C. Danforth, MD	x	x	—
Donald N. Sweeny, Jr., MD	x	x	x
John W. Moses, MD	x	—	—
Paul J. Connolly, MD	x	x	x
Edward J. Tallant, MD	x	x	—
Alexander Blain, III, MD	x	x	—
Robert D. Allaben, MD	x	x	x
James M. Kennary, MD	x	x	—
George F. Porretta, MD	x	x	x
Frank D. Walker, MD	x	x	—
Thomas M. Flake, MD	x	x	—
Raymond J. Barrett, MD	x	x	x
Francis P. Rhoades, MD	x	x	—
Abraham Becker, MD	x	—	—
Richard D. Anslow, MD	x	x	x
Vincent J. Gallant, MD	x	x	x
Eli J. Igna, MD	x	x	—
Arthur B. Eisenbrey, MD	x	x	—
Raymond B. Bauer, MD	x	—	—
Clarence S. Livingood, MD	x	—	—
Kenneth J. Ray, MD	x	x	x
Dwight J. Dutcher, MD	x	x	x
Cecelia F. Hissong, MD	x	x	x
Gerald H. Mandell, MD	x	x	—
Boy Frame, MD	x	—	—
Bruce L. Danto, MD	x	x	—
Harry Tarpinian, MD	x	x	x
H. Richard Henderson, MD	x	x	x
Lee B. Stevenson, MD	x	x	—
James J. Humes, MD	x	x	—
Charles Kessler, MD	x	x	x
Michael N. Zelenock, MD	x	x	x
George A. Kling, MD	x	x	x
Robert P. Lilly, MD	x	x	x
Gomer P. Evans, MD	x	x	x
Louis F. Hayes, MD	x	x	x
Jean M. Holdredge, MD	x	x	x
WEXFORD-MISSAUKEE			
Dennis E. Van Alst, MD	x	x	x
STUDENT AMERICAN MEDICAL ASSOCIATION DELEGATES:			
MICHIGAN STATE UNIVERSITY			
Karin Tansek	x	x	x
WAYNE STATE UNIVERSITY			
Mark Campbell	x	x	—
UNIVERSITY OF MICHIGAN			
William Middleton	x	x	—
MEMBERS AT LARGE:			
Medical School Deans			
MSU			
Andrew Hunt, MD	—	x	x
WSU			
Not Represented			
Immed. Past Pres.			
John J. Coury, Jr., MD	—	—	x
SECTION DELEGATES			
ALLERGY & APPLIED IMMUNOLOGY			
Not Represented			
ANESTHESIOLOGY			
Not Represented			
DERMATOLOGY			
Robert J. Schoenfeld, MD	x	x	x
GASTROENTEROLOGY			
John P. Papp, MD	x	—	—
FAMILY PRACTICE			
Gordon W. Willoughby, MD	x	x	—
INTERNAL MEDICINE			
Bernard J. Sweeney, MD	x	x	x
NEUROLOGY			
Mark C. Levine, MD	x	x	x
NEUROLOGICAL SURGERY			
Not Represented			
OBSTETRICS-GYNECOLOGY			
Joseph A. Caruso, MD	x	x	x
OCCUPATIONAL MEDICINE			
Not Represented			

OPHTHALMOLOGY
Not Represented

ORTHOPEDIC SURGERY
Not Represented

OTOLARYNGOLOGY
Not Represented

PATHOLOGY
Not Represented

PEDIATRICS
Not Represented

PHYSICAL MEDICINE
Not Represented

PLASTIC SURGERY
Not Represented

PROCTOLOGY

Timothy M. Talbott, MD	x	x	x

PSYCHIATRY

Stephen C. Mason, III, MD	x	x	x

PUBLIC HEALTH & PREVENTIVE MEDICINE
Not Represented

RADIOLOGY
Not Represented

SURGERY
Not Represented

THORACIC SURGERY
Not Represented

UROLOGY
Not Represented

respond to one

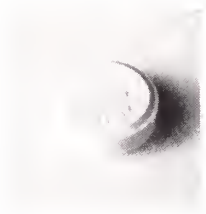
According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

For further information on this subject, the following references are provided:

1. Henry BW, *et al: Dis Nerv Syst 30*:675-679, Oct 1969.
2. Hollister LE, *et al: Arch Gen Psychiatry 24*:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970.



Valium® (diazepam)

2-mg, 5-mg, 10-mg tablets

in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Contents

Michigan Medicine Volume 73, Number 27 Sept. 1974

Michigan Medicine continues its tribute to Saginaw's St. Mary's Hospital with publication of two articles in this issue by St. Mary's staff members. Two scientific articles appeared in the August journal from the hospital, which is celebrating its centennial.

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549 Medieval Medicine and Magic; George E. McKeever, MD, Dearborn
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The cover photograph, of Michigan's Lake Mecosta, is by Thomas R. Roberts, Lansing.

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The Publication Committee of the MSMS Council is the editorial board of *Michigan Medicine* and advises the Council and the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. In editorials, the views expressed are those of the writer and not necessarily official positions of the society.

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Donald N. Sweeny, Jr., MD
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Annual Scientific Meeting Offers Wide Subject Choice to Physicians

Michigan physicians will be offered a major opportunity in continuing medical education Oct. 9 and 10 at the MSMS 1974 Scientific Meeting in the Sheraton-Cadillac Hotel, Detroit.

In two days of programs, physicians may choose from scientific sessions in twenty areas of specialization, led by outstanding speakers and panelists from in and outside of Michigan.

John B. Bryan, MD, of Royal Oak, scientific program coordinator, has had the assistance of MSMS specialty sections and Michigan specialty societies in arranging many of the programs.

Special interest seminars for newly licensed physicians and physicians planning soon to enter private practice also are planned. The annual MSMS leadership conference for component society officers will be held on Thursday, with the society's annual awards ceremonies to be held as part of the conference.

Out of state speakers who have accepted program assignments include Floyd D. Loop, MD, of the Cleveland Clinic, who will take part in a program on "Indications for Surgery in Coronary Artery Disease"; Eugene I. Winkelman, MD, of Cleveland, whose topic will be "Intestinal Shunting: A Medical View"; David H. Baker, MD, of New York City, who will speak to radiologists; Louis Jollyon West, MD, chairman of the UCLA Department of Psychiatry, speaking on "The Study and Control of Violence," and Robert J. Spencer, MD, chief of the Mayo Clinic Division of Proctology, discussing "Office Sigmoidoscopy."

Others will include Robert M. McFarlane, MD, of London, Ont., discussing "Dupuytren's Contracture"; Carl V. Granger, MD, of Boston, whose topic will be "Early Prognosis and Management in Bell's Palsy"; William O. Cuatico, MD, of Huntington Beach, Cal., addressing a program on neurology and neurological surgery; Richard N. Myers, MD, of the surgery faculty at Jefferson Medical College, Philadelphia, speaking on "Problems in Hyperalimentation"; Melville G. Rosen, MD, professor of family practice, State University of New York at Stony Brook, who will be a panelist on "Sexual Education and Counseling in Family Practice," and William P. Jordan, Jr., MD, of Richmond, Va., speaking at a program on dermatology.

Preliminary programs listing details for the scientific meetings are being mailed to all MSMS members. The accompanying chart gives times and subjects for the sessions.

Here Is List of Exhibits for Scientific Program

More than 30 firms will provide educational and general exhibits for the 1974 Scientific Meeting Oct. 9 and 10 in the Sheraton-Cadillac Hotel. Many of the pharmaceutical firms represented will have technical representatives on hand to discuss products with physicians and to answer questions.

Morning and afternoon recesses are provided during each day's sessions to provide ample time for visiting exhibits.

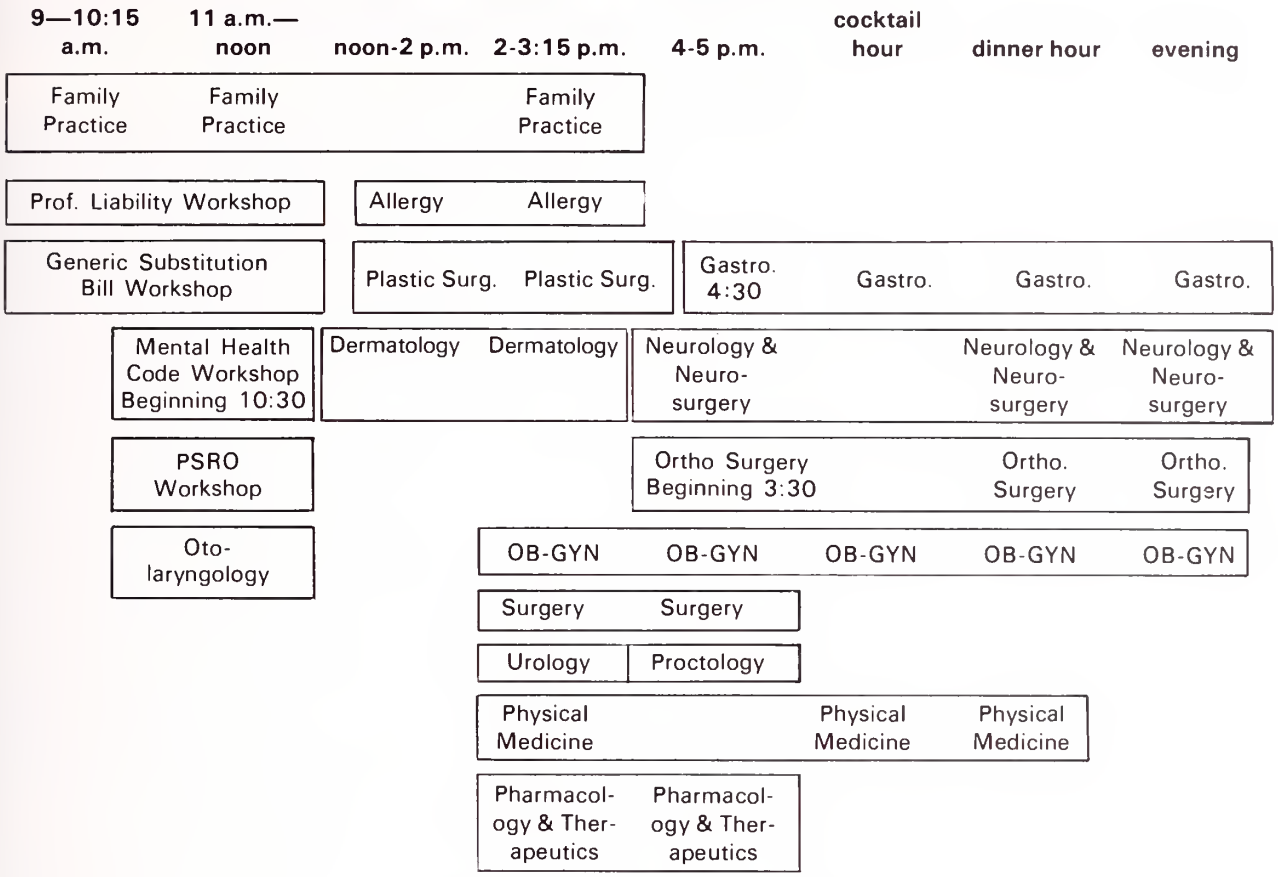
Following is the list of exhibitors:

Abbott Laboratories
Advance Medical and Research Center
Breon Laboratories
Coca Cola
Control-O-Fax
Dow Lepetit
Encyclopedia Britannica
Ferndale Laboratories
Gerber Products Co.
Hack Shoe Co.
Hoechst Pharmaceuticals
Laboratory Procedures, Upjohn Co.
Lederle Laboratories
Eli Lilly & Co.
Loma Linda Foods
Mead-Johnson Laboratories
Medical Plastics Laboratory
The Medical Protective Co.
Michigan Association of Collection Agencies
Michigan Blue Shield
North American Pharmacal
Ortho Pharmaceutical Corp.
Parke, Davis & Co.
Physicians Planning Service Corp.
Sandoz Pharmaceuticals
W. B. Saunders Co.
Searle Laboratories
Stratton, Cheeseman and Associates, Inc.
S. J. Tutag & Co.
The Upjohn Co.
USV Pharmaceuticals Corp.

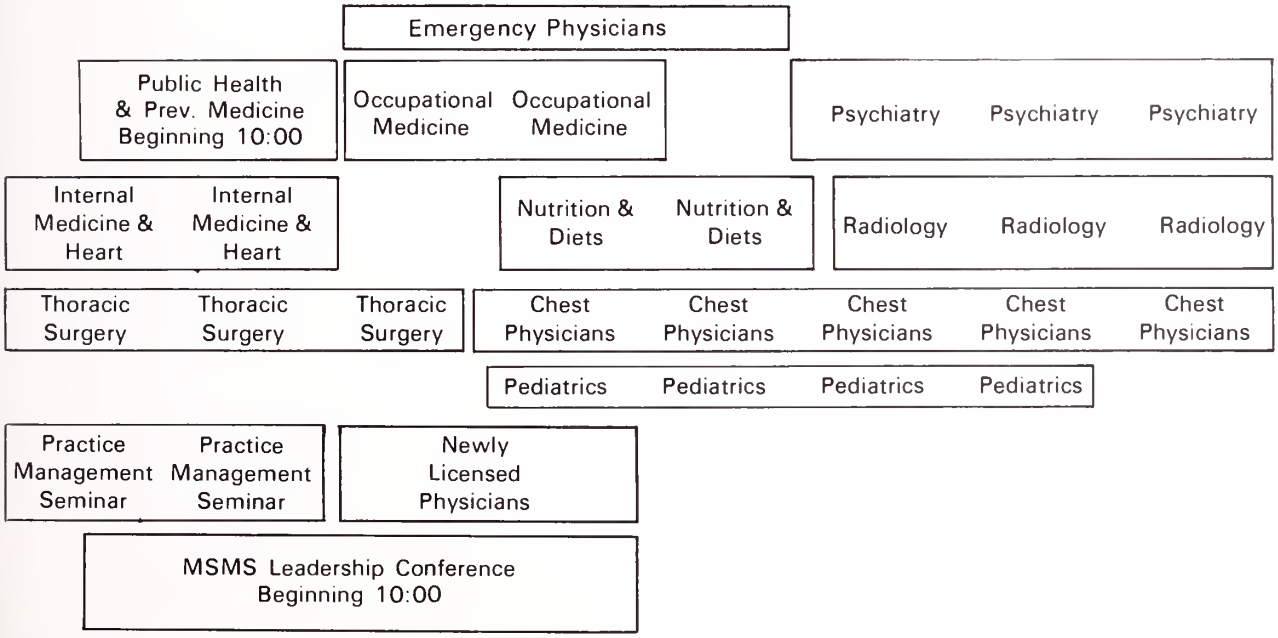
Three firms which will not provide exhibits have made donations to help offset costs of the session. They are Merck Sharp & Dohme, A. H. Robins Co. and Smith Kline & French Laboratories. Several educational exhibits have been arranged by specialty societies.

Time and Subject Schedule for 1974 Scientific Meeting Oct. 9 & 10, Sheraton-Cadillac Hotel

Wednesday, October 9



Thursday, October 10



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Trobicin—Indication and dosage.
Spectinomycin is indicated only for use in acute urethritis and proctitis in the male and acute cervicitis and/or proctitis in the female when due to susceptible strains of *N. gonorrhoeae*. The usual dosage for Trobicin in adult males is 2 grams intramuscularly†; 4 grams intramuscularly in females.

Trobicin—Not effective for syphilis.
Trobicin is not effective for any stage of syphilis. Trobicin may mask or delay the symptoms of incubating syphilis. If concurrent syphilis is suspected, follow the patient serologically for at least 3 months. Patients with syphilis should receive adequate specific anti-syphilitic therapy with an appropriate antibiotic.
Trobicin is contraindicated in patients previously found hypersensitive to it.

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sterile spectinomycin hydrochloride

Sterile Trobicin
Sterile Trobicin (spectinomycin hydrochloride) —For Intramuscular Injection:
2 gm vials containing 5 ml when reconstituted with diluent.
4 gm vials containing 10 ml when reconstituted with diluent.
An aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria gonorrhoeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between spectinomycin and penicillin.

Indications: Acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

Contraindications: Contraindicated in patients previously found hypersensitive to spectinomycin.

Warnings: Not indicated for the treatment of syphilis. Antibiotics used to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Patients should be carefully examined and monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected.
Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions should be observed with atopic individuals.
Clinical effectiveness should be monitored to detect evidence of development of resistance by *N. gonorrhoeae*.

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single- and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25° C and use within 24 hours after reconstitution with diluent.

Male—Inject 5 ml intramuscularly for a 2 gram dose. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.

Female—Inject 10 ml intramuscularly for a 4 gram dose.

How supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of 400 mg spectinomycin per ml (as the hydrochloride). For intramuscular use only.
Susceptibility Powder—for testing *in vitro* susceptibility of *N. gonorrhoeae*.
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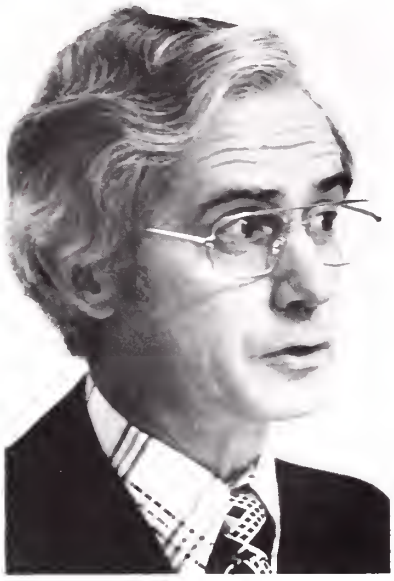
†For patients with gonorrheal proctitis and for patients in geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams is preferred.

President's Page



Doctor Masters

Family Practice Needs to Grow

As a family physician who happens to be president of the Michigan State Medical Society this year, I would like to describe some of the specific problems I see facing the family physician in Michigan and the nation.

1. There is the need in our nation and in Michigan for more compleat physicians. The people desperately need more broad-based doctors who are capable of directing the health care team. We need the kind of doctor who can insure that the benefits of scientific research will indeed reach the greatest number of people in the most economic manner.

2. I see an uphill struggle to establish family practice in its proper place in medical schools and in the hospital postgraduate training programs. The Michigan Academy of Family Physicians has accomplished much already. But the idea of a medical school department of family practice is not yet widely accepted. Family practice residency programs are increasing in Michigan, but we must help hospitals work out some of the financial problems. And we must help hospitals obtain the best possible preceptors to set the right example for the future family physicians.

To overcome these problems, family physicians and all doctors have opportunities to work in a number of specific areas. For example, we must capitalize more on the new receptive climate for continuing medical education. Before the government mandates postgraduate education, let's make a voluntary approach work.

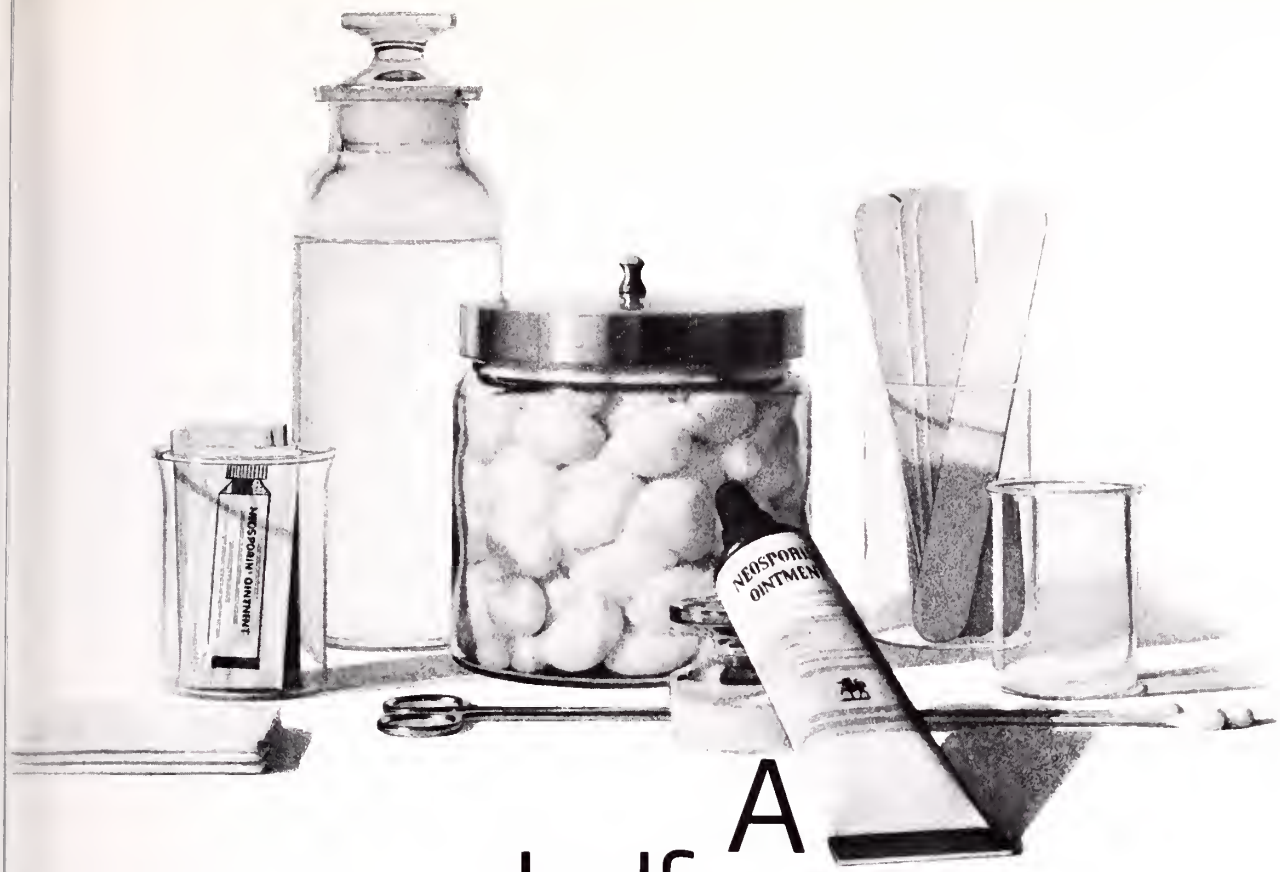
Family doctors can play an active part in MSMS efforts to educate both the profession and the public about the shortcomings of chiropractic. I am certain the general public does not want chiropractors to be permitted to perform surgery, to practice psychiatry, etc., as chiropractors seek in HB5777 in the Michigan legislature.

Family doctors must continue to urge the deans of medicine to develop strong departments of family practice and to work with hospitals to establish more family practice residencies. Family physicians also should continue to negotiate with various interests to remove the inequalities that today hamper the growth of family practice.

The medical profession and family practice physicians face some tough days ahead. There have always been pebbles along the way. And it seems to me that some large rocks are being tossed in the way today by government laws and regulations. But one of the biggest roadblocks could well be our own complacency, indifference, apathy.

(Excerpted from an address before the Michigan Academy of Family Physicians at its 1974 annual assembly in July at Traverse City)

Brooker L. Masters, MD



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CONTRAINDICATIONS: Not for use in the eyes or external ear canal if the eardrum s perforated. This product is contraindicated in those individuals who have hown hypersensitivity to any of the components.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity lue to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

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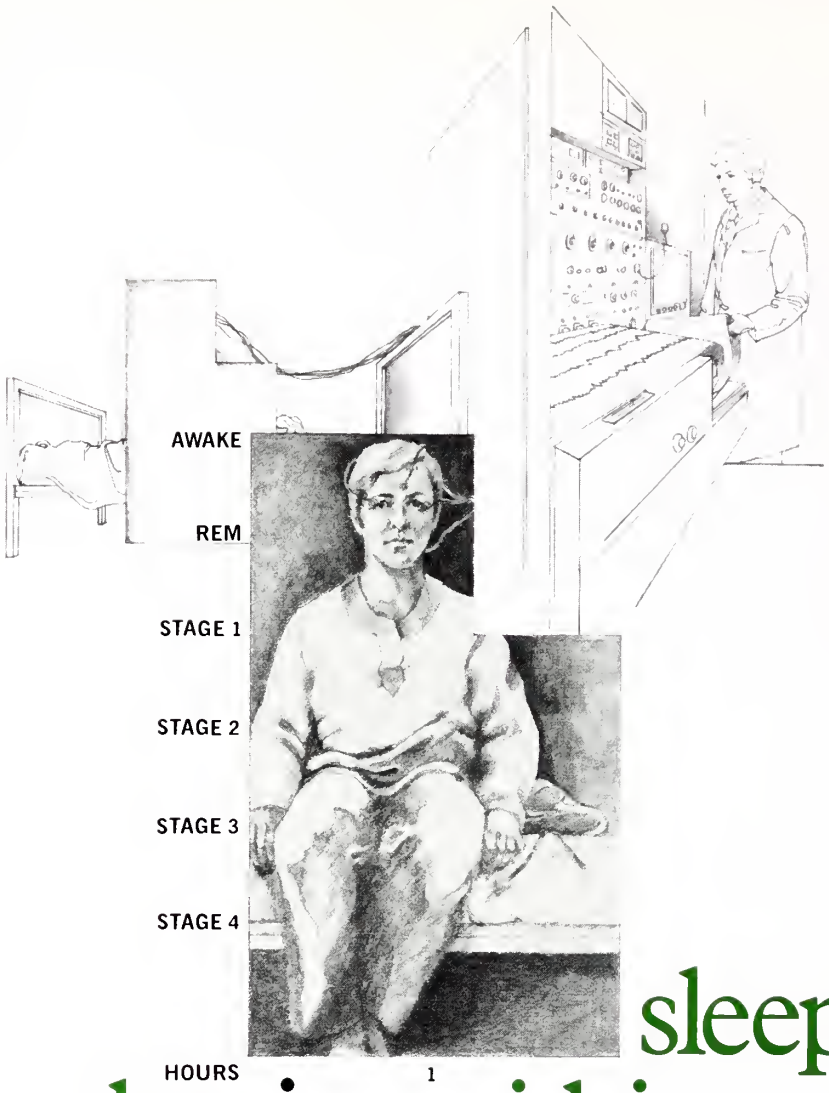

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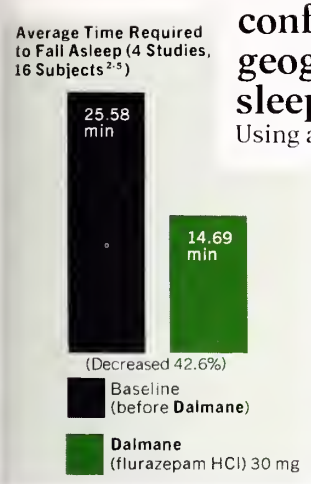

Average Time Required to Fall Asleep (4 Studies, 16 Subjects[2-5])
25.58 min
14.69 min
(Decreased 42.6%)
Baseline (before Dalmane)
Dalmane (flurazepam HCl) 30 mg

confirmed by clinical studies in four geographically separated sleep research laboratories[2-5]

Using a 14-night protocol involving eight insomniac and eight normal subjects, four studies confirmed the sleep-inducing effectiveness of Dalmane (flurazepam HCl) and the reproducibility of this response. On average, one 30-mg capsule induced sleep within 17 minutes. In all these studies, Dalmane induced sleep rapidly, reduced nighttime awakenings, and provided 7 to 8 hours of sleep without repeating dosage.[2-5]

Dalmane (flurazepam HCl) induces and maintains sleep, with relative safety

Dalmane is generally well tolerated; morning "hang-over" has been relatively infrequent. While dizziness, drowsiness, lightheadedness and the like have been noted most often, particularly in the elderly and debilitated, physicians should be aware of the possibility of more serious reactions, as noted below.

Before prescribing Dalmane (flurazepam HCl), please eonsult Complete Produet Information, a summary of whieh follows:

Indieations: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindieations: Known hypersensitivity to flurazepam HCl.

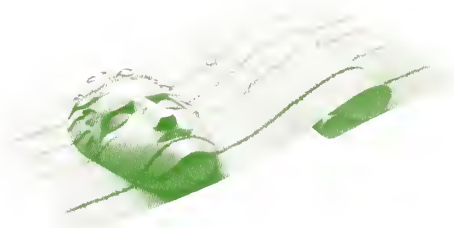
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Preeautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reaetions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



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- induces sleep within 17 minutes, on average
- reduces nighttime awakenings
- sustains sleep 7 to 8 hours, on average, without repeating dosage

REFERENCES: 1. Kales A, *et al*: *Arch Gen Psychiatry 23*:226-232, Sep 1970
2. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971
3. Frost JD Jr: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
4. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
5. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ

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Scientific Articles

Is Congenital Hypoplastic Pulmonary Artery Truly Hypoplastic?

By John L. Shek, MD, FACCP, Saginaw and Raymond J. Barrett, MD, FACCP, Detroit

ABSTRACT

A case diagnosed as unilateral hyperlucent lung and congenital hypoplasia of left pulmonary artery fortuitously co-exists with an intraluminal bronchial adenoma. Bronchotomy for the removal of this adenoma necessitated lysis of the small pulmonary artery. Postoperative course shows increasing vascularity and perfusion of the left lung as well as the increase in size of the left pulmonary artery and its branches to almost normal dimension. Is congenital hypoplastic pulmonary artery truly irreversible?

The recognition of a radiologically demonstrable increased lucency of one lung as a clinical entity was well established in 1952 by Madoff [5] and his group, and in 1953 by Sawyer and James.[10] The former reported it emphasizing the congenital absence of pulmonary artery and the latter stressed lung findings under the name of unilateral pulmonary emphysema. Numerous articles since that time agree that this entity has two characteristics, (1) the reduced blood flow with poor arteriographic visualization of the pulmonary artery and (2) the varying degrees of airway obstruction in the hyperlucent lung. Culiner and Weg[1] have done much to categorize the clinical entities with unilateral hyperlucent lung in the x-ray picture by excluding cases due to abnormality of the chest wall and the parenchyma. The following is a report of a patient who was diagnosed as congenital hypoplastic pulmonary artery with unilateral hyperlucent lung complicated by a coexisting intraluminal bronchial adenoma. This case presents a few interesting points:

A.S., female, age 26, was first seen on 4/28/71 complaining of some vague chest pain and dyspnea and non-productive cough intermittently for 2+ years. There was no history of purulent expectoration nor hemoptysis. The x-ray films taken on 4/30/71 showed a hyperlucent left lung with small left hilum and almost absent pulmonary markings. An EKG was normal. There were no murmurs. There were slightly diminished breath sounds and a few rhonchi on the left. Diagnosis of congenital hypoplastic pulmonary artery with unilateral hyperlucent lung was made. A lung scan done on 5/3/71 showed no perfusion of the left lung. The chest x-ray showed similar unilateral hyperlucent lung with small pulmonary artery and lack of bronchovascular pattern. There was no solid lesion of the parenchyma nor shifting of the mediastinum. On 10/4/71 a pulmonary angiogram was done with a diagnosis of "congenital small left pulmonary artery." A bronchoscopy in October, 1971, revealed a small intraluminal tumor, biopsy of which was interpreted as benign adenoma. A

(Continued)

Michigan Medicine *continues its tribute to the centennial celebration of St. Mary's Hospital, Saginaw, by publishing two more articles by authors from St. Mary's staff. Two articles by St. Mary's staff members appeared in August.*

Fig. 1. Chest x-ray, May 1971.

Fig. 2. Lung scan, Oct. 19, 1971.

Fig. 3. Lung scan, Nov. 8, 1971.

lung scan repeated on 10/9/71 still showed no perfusion on the left. Respiratory function test of 10/9/71 showed total vital capacity of 66%, FEV-1 84%, FEV-2 94% and MBC 69% of normal. Serum electrophoresis was normal with .2 grams of Alpha-1 globulin.

Because of this bronchial adenoma a thoracotomy and left main bronchotomy was done on 10/20/71. A small grayish pink and soft tumor was removed. It was entirely intraluminal with a base measuring 0.1 centimeters in diameter from the bronchial mucosa only. This was totally excised and the pathologist reported it to be as a bronchial adenoma.

While dissecting the left main stem bronchus for the bronchotomy the pulmonary artery was found to be about 1/4 of the expected size. There were some adhesions in this area and these were dissected free. The pulmonary artery did not increase in size right away. These adhesions did not give the appearance of being secondary to chronic infection. There were no lymph nodes in the area.

Postoperatively the patient did well and was discharged in good condition. On 11/8/71 a lung scan was repeated and it showed some perfusion on the left. On 6/20/72 another lung scan was performed and it showed almost normal perfusion at this time. With regard to the respiratory function, tests on 3/15/72 showed a 100% total vital capacity, FEV-1 94%, FEV-3 98%, MBC 106%. An x-ray taken on 6/7/72 shows "reduced bronchovascular pattern on the left which has been previously present is not as apparent at this time." The left lung on physical examination now shows near normal breath sound. A repeat pulmonary angiography was not done. On Sept. 21, 1972, arterial blood gas study revealed PH of 7.46, oxygen saturation 96.2%, PO_2 83, PCO_2 39, HCO_3 27, excess base +3.

Discussion

The controversy still existing today with regard to this unilateral hyperlucent lung syndrome centers now in the question as to which is first, the chicken or the egg. In other words, Kent[4] believes that the vascular abnormality is the primary cause of the disease entity with the respiratory or bronchopulmonary condition as secondary complication. Conversely, MacLeod[9] and Prowse[8] supported a basic pulmonary lesion in the form of obliterative bronchiolitis (*which is not present in our case*) with secondary changes in the size of the pulmonary vasculature. Figueroa-Casas,[2] et al., perfer to believe that some "basic fundamental disorder of growth and development of the lung and its circulation" to be responsible for this disease entity.

Our case provided the opportunity for a thoracotomy and lysis of the "adhesions" because of a coincidental intraluminal bronchial adenoma. The lysis of the adhesions of the so-called congenital small pulmonary artery was done as an incidental but necessary part for bronchotomy. The end result of increased lung perfusion as demonstrated by the lung scan and the increased pulmonary vasculature as demonstrated by the near normal bronchopulmonary pattern is of

Fig. 4. Chest x-ray, June 7, 1972.

Fig. 5. Lung scan, June 20, 1972.

definite significance. It would seem that at least in some instances the radiological reading of small pulmonary artery labeled as congenital is open to question. "Congenital" implies an irreversible anomaly by birth unless by surgery while this case showed it to the contrary. In the last analysis how does one come to the conclusion that radiologically one can label a small pulmonary artery congenital or acquired even though statistically more are congenital?

The increase of pulmonary perfusion and increase in size of the pulmonary artery in this case would seem to be due to the fact that the small pulmonary artery was dissected free. The removal of the small intraluminal bronchial adenoma which had not given rise to bleeding, total obstruction or infection distal to it could hardly be the cause of the improvement in the pulmonary artery perfusion. However, one cannot deny in view of the reduced respiratory function test results preoperatively that the adenoma was involved in the disturbance in the ventilatory aspect of respiration. The return of such values to near normal in this case could be due to the removal of the intraluminal bronchial adenoma or is it due to the lysis of the adhesion of the small pulmonary artery causing a return of blood flow and size of arterial tree. One wonders whether in the so-called congenital hypoplastic pulmonary artery situation that it is not due to adhesions limiting the flow and is reversible by lysis.

Since congenital lesions of the intrapulmonary vasculature are in general non-remediable, it is obvious that complete reliance on the radiographic interpretation of congenital hypoplasia could have led to a possible decision to perform pneumonectomy on a patient with a main stem adenoma and apparently non-perfused lung. At least, if it is reversible, one might increase the perfusion of the affected lung. The waste of the potential function of a lung with hypoplastic artery needs no elaboration.

Summary

Theories regarding hyperlucent lung and hypoplastic pulmonary artery have been discussed.

A fortuitous circumstance in which bronchial adenoma associated with "hypoplastic pulmonary artery," led to lysis of the pulmonary artery with progressive return to near normal size of the vasculature is discussed.

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Education

Two Medical Schools Push Ahead in Education for Family Practice

Recent announcements from medical schools at Wayne State and Michigan State universities indicate growing focus by Michigan medical educators on training students for family practice.

The WSU School of Medicine, after a search that covered several months, announced the appointment of Joseph W. Hess, MD, who lives in Farmington Hills, as professor and first chairman of its recently created Department of Family Medicine. Doctor Hess received his medical degree from the University of Utah in 1956 and completed internship and residencies in internal medicine and neurology at Detroit Receiving Hospital. He joined the WSU faculty in 1960.

Dr. Hess

Meanwhile, the MSU College of Human Medicine announced it had received a commitment of $667,931 from the Kellogg Foundation to be used over the next four years to develop a department of family practice. MSU also has been searching for a chairman for family practice for several months, but hasn't announced a selection.

Brock E. Brush, MD (right), MSMS president-elect; Wayne State University President George E. Gullen, Jr., (center), and Robert D. Coye, MD, WSU medical dean, view models of the new WSU Clinics Building and the new Detroit General Hospital, to be built in the Detroit Medical Center at a total cost of 115 million dollars. The project is expected to take five years to complete.

Post Traumatic Pulmonary Insufficiency: *Recognition and Management of this Syndrome in a Community Hospital*

By Khan Z. Masud, MD, and Kenneth J. Forster, MD
Saginaw

The Syndrome of Post Traumatic Pulmonary Insufficiency, (PTPI) has been referred to as Shock Lung, Da Nang Lung, congestive atelectasis, adult respiratory insufficiency syndrome, etc. Post traumatic pulmonary insufficiency is a response by the lung to direct or indirect pulmonary trauma. It also has some characteristic features of its own, such as tachypnea, progressive and refractory hypoxemia, decreasing lung compliance, reduced functional residual capacity (FRC) and increased alveolar-arterial oxygen difference ($A\text{-}aDO_2$).[1-5] Loss of surfactant activity,[3] increased pulmonary interstitial water,[7] increased pulmonary capillary permeability[6] and increased pulmonary arteriovenous admixture[2] have also been shown to be part of the pathological picture of this syndrome.

An aggressive and intensive therapeutic approach has been shown to be effective in a significant number of patients suffering from PTPI. A favorable outcome depends upon early recognition and intensive medical and nursing care by personnel trained in the treatment of critical pulmonary problems and on prevention of complications such as aspiration pneumonitis, septicemia, lung abscess, etc.

Intensive care of such critically ill patients increases the cost of their medical care astronomically. This raises the question whether such patients should be cared for in large medical centers or in regional peripheral hospitals with sepcial facilities. Large medical centers should care for these patients. However, because of the sheer volume involved, some of these patients will be taken care of in the regional community hospitals with critical care facilities.[13] In view of the burgeoning number of these patients, St. Mary's Hospital, Saginaw, Mich., has formed a Department of Respiratory Care and Inhalation Therapy. The total number of patients admitted to the I.C.U. with the diagnosis of acute post traumatic pulmonary insufficiency (PTPI) in the last two years is presented in Table I.

Abbreviations Used

PTPI	—	Post Traumatic Pulmonary Insufficiency
PaO_2	—	Arterial Oxygen tension
PvO_2	—	Venous Oxygen tension
$A\text{-}aDO_2$	—	Alveolar — arterial oxygen tension difference
VD/VT	—	Dead space to tidal volume ratio
QS/QT	—	Right to left shunt
FRC	—	Functional Residual Capacity
PEEP	—	Positive End Expiratory Pressure
FiO_2	—	Fraction of Inspired Oxygen concentration

Table I

Year	No. of Pts. on Ventilator	No. of Deaths	No. of Pts. Recovered	Survival Percent	No. of Days on Ventilator
1973	22	9	12	59%	225
1974	36	15	21	58%	325

(Continued)

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Doctor Forster is chief, Department of Anesthesiology, St. Mary's Hospital, and assistant clinical professor of surgery (anesthesia), Michigan State University.

SAINT MARY'S HOSPITAL 1874 1974 SAGINAW, MICHIGAN

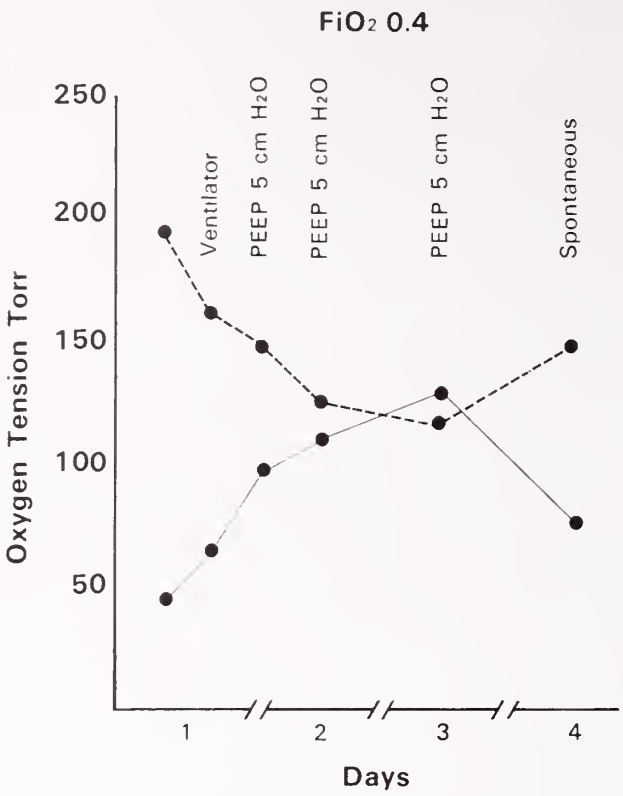

Fig. 1: Solid lines represent the Arterial Oxygen tension. Broken lines represent the Alveolar arterial oxygen difference. Note the improvement in PaO_2 after addition of PEEP.

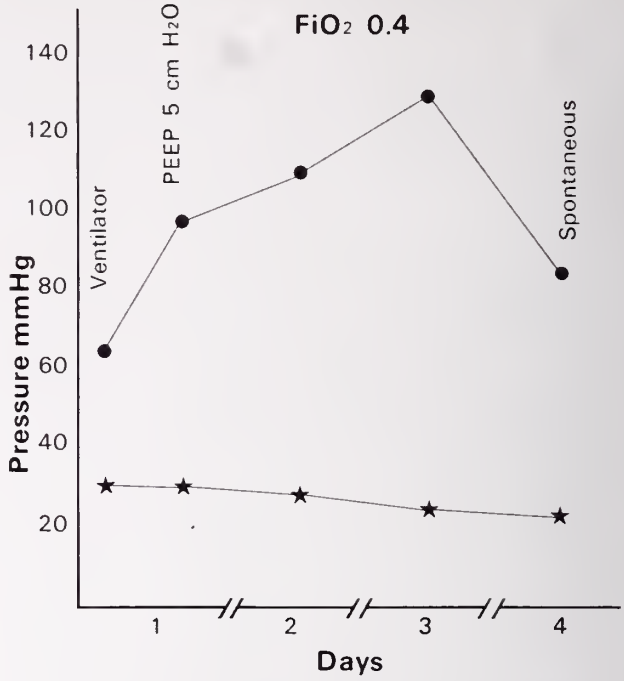

Fig. 2: The bottom line represents the Pulmonary Artery Systolic Pressure. The top line represents the Arterial oxygen tension.

The following two cases illustrate the clinical picture and the management of PTPI.

Case Report I

A 35-year-old white male was admitted through the emergency room after an automobile accident. He was semi-comatose with a pulse rate of 110/min, blood pressure of 110/90 mmHg and respiratory rate of 24/min. His pupils were equal and reacting. There was tenderness over his right upper quandrant and his abdominal tap was positive for blood in the abdomen. His chest x-ray showed multiple rib fractures on the right side and a right pneumothorax. His hemoglobin was 11 Gm% and urinalysis was normal. A chest tube was placed in the right hemithorax and connected to a water seal bottle. An emergency exploratory laparotomy was performed during which a laceration of the right lobe of the liver and a mesenteric rupture were repaired. The patient received 1000 ml of blood and 1500 ml of balanced salt solution during the operation. Four hours post-operatively, the patient became tachypneic with a respiratory rate of 34/min and was placed on 40% O_2 through the venti-mask. His chest x-ray revealed bilateral diffuse infiltrates compatible with pulmonary edema. A central venous catheter was placed through the internal jugular vein and a reading of 9 cm H_2O was recorded. Arterial blood for gas analysis was drawn while the patient was breathing 40% oxygen through the venti-mask. They showed a PaO_2 of 48 mmHg, $PaCO_2$ of 36 mmHg, and pH of 7.40. His tidal volume was 700 ml, VD/VT was 0.45, and vital capacity was 2000 ml. A double lumen Swan-Ganz catheter[10] was placed in the pulmonary artery through the ante cubital vein. Pulmonary artery (PA) pressure was displayed and recorded on the Gould Oscilloscope and recorder via a Statham P-37 transducer. The capillary wedge pressure (CWP) was checked by inflating a balloon on the tip of the S-G catheter. PA pressure at this point was 30/15 mmHg and the CWP was 10 mmHg. Day to day readings of his PA pressure are shown in Fig. 2. The right to left shunt (QS/QT) was calculated after administering to the patient 100% oxygen for 20 minutes and collecting his blood samples from PA and the radial artery for blood gas analysis. Computer produced Physiological Tables of Kellman and Nunn were then used to calculate QS/QT according to the formula $\frac{CcO_2 - CaO_2}{CcO_2 - CvO_2}$. The value of QS/QT obtained was 20%. The patient was then intubated using a naso-tracheal tube and his ventilation was controlled by Bennett MA-1 ventilator with a tidal volume of 1000 ml and FiO_2 of 0.4. Results of his arterial PaO_2 and A-aDO_2 are shown in Fig. 1. Because of little improvement in his PaO_2, a

positive end expiratory pressure (PEEP) of 5 cm H_2O was added which resulted in considerable improvement of his arterial oxygen tension. Hydration status of the patient was monitored by CVP, urine output and the Serum and urine osmolalities. His hemoglobin, serum electrolytes and serum proteins were kept within normal limits by using indicated therapy.

The patient's general condition, including oxygenation, improved over the next four days. On the fourth post-operative day, an attempt to wean the patient off the ventilator was made. The patient was allowed to breathe spontaneously for 15 minutes while receiving 40% oxygen via a T-tube. At the end of 15 minutes, his arterial blood gas analysis showed a PaO_2 of 68 mmHg, $PaCO_2$ of 42 mmHg, a pH of 7.44 and a base change of +2 mEq/L. His tidal volume was 550 ml, his VD/VT was 0.4, his vital capacity was 2200 ml and his inspiratory force was 18 mmHg. The PA pressure was 22/8 mmHg, CWP, 10 mmHg and QS/QT 10%. A chest x-ray showed significant clearing of infiltrates.

Extubation of the patient was done on the sixth post-operative day. He was able to sit up in the chair and was given a liquid diet. He was discharged from the Intensive Care Unit on the seventh post-operative day.

Comments

This case illustrates the development of refractory hypoxemia, large A-aDO_2, QS/QT and increased pulmonary artery pressure, characteristics of PTPI. The possibility of pulmonary edema of cardiac origin was ruled out because of normal CVP and CWP. A negative serum fat stain and absence of petechiae ruled out fat embolism. The radiological picture and history were not consistent with aspiration pneumonitis. A tracheal culture did not grow any pathogenes and the patient's temperature did not rise above 101°F (rectal) for any two consecutive days. The possibility of acute pneumonitis was therefore excluded.

Therapy consisted of; maintaining proper hydration, adequate hemoglobin and proteins, normal serum electrolytes and urine output and avoiding infection, in addition to maintaining proper oxygenation. Maintenance of adequate PaO_2 with low FiO_2 was greatly facilitated by the addition of PEEP. These measures resulted in recovery of the patient who was finally discharged from the hospital in a satisfactory condition.

(Continued)

MICHIGAN DEPARTMENT OF PUBLIC HEALTH

Monthly Surveillance Report

Cases of Certain Diseases
Reported to the Michigan Department of Public Health
For the five-week period ending Aug. 2, 1974

	1974 This 5-Week Period	1973 Same 5-Week Period	1974 Total To Above Date	1973 Total Same Date	Total Cases for 1973
Rubella	56	83	1,147	1,781	2,001
Cong Rubella Syndrome	0	0	0	1	4
Measles	66	170	1,886	4,302	4,552
Whooping Cough	23	5	51	44	86
Diphtheria	0	0	0	0	0
Mumps	174	103	5,308	3,854	5,042
Scarlet Fever & Strep Sore Throat	974	1,238	25,064	14,365	24,467
Tetanus	0	1	1	1	2
Poliomyelitis (paralytic)	1	0	1	0	0
Hepatitis	315	331	2,252	2,282	3,872
Salmonellosis (other than S. typhi)	101	83	625	377	795
Typhoid Fever (S. typhi)	3	0	6	6	14
Shigellosis	150	64	674	349	623
Aseptic Meningitis	8	47	63	118	434
Encephalitis	6	14	34	98	163
Meningococcic Meningitis	6	4	34	36	54
H. Influenza Meningitis	13	4	80	70	89
Tuberculosis	140	139	829	960	1,380
Syphilis	231	385	1,741	2,659	4,328
Gonorrhea	2,810	3,209	18,270	17,021	31,128

Information can be supplied by the local health department on the local incidence of disease

Maurice S Reizen, MD, Director
Michigan Department of Public Health

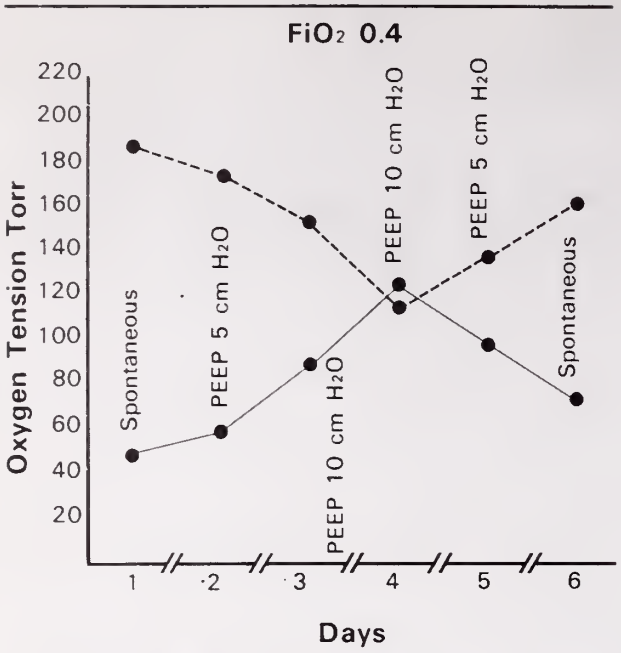

Fig. 3: The solid line represents the arterial oxygen tension. The broken line represents the alveolar arterial oxygen tension difference.

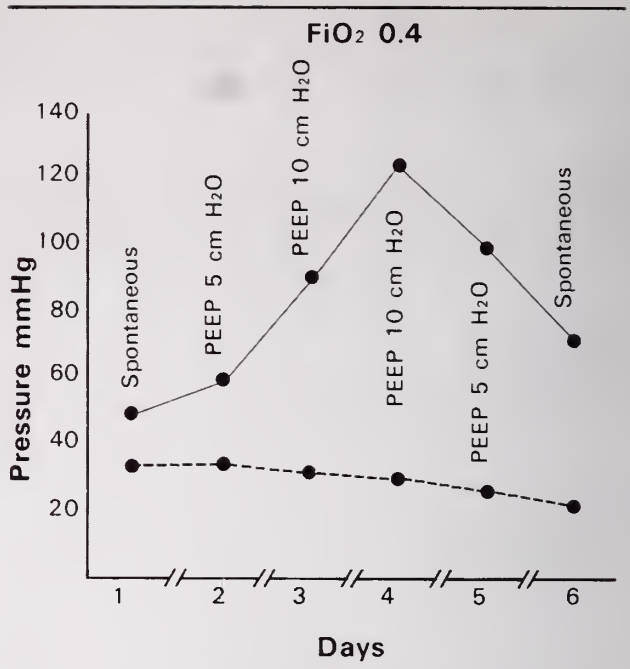

Fig. 4: The solid line represents the arterial oxygen tension. The broken line represents the systolic Pulmonary Artery Pressure. Note the fall in PA pressure as the PaO_2 improves.

Case No. II

A 29-year-old white male was admitted through the emergency room after his truck rolled over in a ditch. At the time of examination in the emergency room, the patient was conscious, coherent, pale and diaphoretic. His pulse rate was 120/min, blood pressure 90/60 mmHg and his respiratory rate 26/min. Hemoglobin was 10 Gm% and his urinalysis was normal. He sustained fractures of left femur and tibia and multiple rib fractures on the right side. A chest x-ray revealed hemopneumothorax. His abdomen was tender on palpation and the abdominal tap revealed the presence of blood in his abdomen. A chest tube was placed in the right hemithorax and connected to a water seal drainage bottle. Approximately 250 ml of blood was drained from his chest. After the usual resuscitative measures, the patient was taken to surgery where a splenectomy was performed along with a repair of liver and mesenteric lacerations. His left femur and tibia were placed in traction to immobilize the fracture site.

Twelve hours post-operatively, the patient became restless, tachypneic, dyspneic and diaphoretic. At this time his pulse rate was 114/min, his blood pressure 120/90 mmHg and his respiratory rate 40/min. Urine output was good and his temperature was 100°F (rectal). Oxygen was being administered by a 40% venti-mask. Arterial blood for gas analysis was drawn and a chest x-ray was taken. Blood gas analysis showed a PaO_2 of 42 mmHg, $PaCO_2$ of 40 mmHg, a pH of 7.38 and a base change of -5 mEq/L. Chest x-ray showed partial re-expansion of the lung and minimal penumothorax. Tidal volume was 650 ml, the VD/VT ratio 0.50 and vital capacity 1800 ml. His inspiratory force was 14 mmHg.

A nasotracheal tube was placed into the patient's trachea and mechanical ventilation was started by means of MA-1 Bennett ventilator with an FiO_2 of 0.4, tidal volume of 1000 ml and a PEEP of 5 cm H_2O. A triple lumen Swan-Ganz Catheter was placed into the pulmonary artery via the ante cubital vein. The proximal lumen was connected to a CVP water manometer and the distal lumen was connected to a Gould pressure display unit and recorder via a Micron transducer. An 18 gauge teflon catheter was placed in the radial artery and connected to a pressure display unit through another Micron transducer. The QS/QT was calculated as described in Case I and was found to be 30%. Arterial blood gas results and the pulmonary artery pressure recordings are shown in Figures 3 and 4. PEEP was increased to 10 cm H_2O because of unsatisfactory improvement in PaO_2 and this resulted in an increase of PaO_2. At this point the CVP was 12 cm H_2O, urine output ranged from 30-60 ml/hrs and his temperature was 100.4°F (rectal). Hemoglobin was 11.4 Gm% and his electrolytes and BUN were normal. A chest x-ray showed bilateral fluffy exudates, more so on his right lung. The patient was conscious, coherent and cooperative.

Gradually the patient improved and weaning from the ventilator was started on the sixth post-operative day. He was allowed to breathe spontaneously for 15 minutes while receiving 40% oxygen via a T-tube. At the end of 15 minutes his tidal volume was 470 ml, his vital capacity was 2500 and his inspiratory force was 20 mmHg. Arterial blood gases showed a PaO_2 of 70 mmHg, $PaCO_2$ of 42 mmHg and a pH of 7.40. Extubation was done on eighth post-operative day. An open reduction of femur and tibial fracture was performed on 10th post-operative day and this patient was discharged from I.C.U. on 15th day after his admission.

Comments

Although this patient had suffered a more extensive trauma, the clinical picture of his pulmonary insufficiency was very similar to that of Case I. The serum fat stain was negative in this patient and his CWP also remained within normal limits. Radiological picture of chest, as happens frequently with PTPI, did not show any significant change until 12 hours after the trauma. Presence of hypoxemia which did not respond favorably to increased FiO_2 was another diagnostic clue.

The management of this patient was essentially similar to Case I. More extensive trauma necessitated more prolonged ventilatory support and higher values of PEEP. Other supportive measures consisted of maintaining good tissue perfusion and adequate oxygen carrying capacity. This patient was finally discharged from the hospital in a satisfactory condition.

Discussion

Patho Physiology. The entire sequence of events in the patho physiology of PTPI is not clearly understood although certain patterns are emerging as a result of concentrated work in this field. The PTPI is basically a non-specific response to lung injury.

A reduction in FRC has been shown to occur in patients with pain, abdominal distention, narcotic drugs and breathing at low volumes.[4] There is an increase in the pulmonary arterio-venous admixture and fall in PaO_2 as the FRC is reduced. The hypoxemia thus produced along with poor tissue perfusion in severely traumatised and hypovolemic patients, tends to promote anerobic glycolysis and therefore lactic acidosis. A combination of hypoxemia and acidosis raises the pulmonary artery (PA) pressure. Increased PA pressure may further aggravate the right to left shunt QS/QT.[2]

Evidence of increased water retention in patients on mechanical ventilation has been presented by Sladen et al.[11] Patients with shock or sepsis have also shown increased pulmonary extra vascular water. This may be a result of capillary endothelial damage.[9,12] Initially there is leakage of water with interstitial pulmonary edema which is soon followed by loss or proteins, increasing edema, hemorrhage and filling of alveoli with proteins, fluid and cellular debris.[5] The "stuffed" alveoli may further increase the QS/QT. Decreasing alveolar perfusion may also interfere with surfactant manufacture by Type II pneumocytes and the loss of surfactant may produce an abnormal tendency to early airway closure.[3]

The net result of alveolar closure, reduced FRC and increased QS/QT is progressive and refractory hypoxemia which is the hallmark of PTPI.

Management

Since the outstanding feature of PTPI is hypoxemia, the therapeutic measures should be directed toward the correction of low PaO_2. The therapeutic approach is graded according to the response of the patient. If oxygen administration by mask alone does not correct the hypoxemia, the next step should be intubation and assisted ventilation. Initiation of artificial ventilation should be considered after taking into account the blood gases, A-aDO_2, VD/VT and QS/QT ratio, vital capacity and inspiratory and expiratory forces. Use of large tidal volumes (12-15 ml/kg) is generally recommended. If high inspired oxygen concentration (over 50%) is required to maintain a PaO_2 of 70 mmHg, addition of positive and expiratory pressure (PEEP) should be considered.[3,4]

Presumably, the addition of PEEP increases the FRC,[4] and increases the pressure gradient between alveolar and pulmonary capillary pressure.[15] Both processes result in reduction of QS/QT and better oxygenation.

Maintenance of adequate cardiac output is also necessary to ensure acceptable PaO_2. Low cardiac output will result in low PvO_2 and therefore, low PaO_2. Maintenance of normovolemia and good myocardial activity — with the aid of inotropic agents if needed — will keep the cardiac output within acceptable limits. CVP is not a very reliable guide of adequate hydration in patients with PTPI, since left heart failure may be present in the fact of normal CVP.[4] The use of Swan-Ganz catheter has been of great help in not only measuring the PA pressure but also monitoring the CWP which is an indirect but a reliable index of left heart activity.

Since the oxygen content of blood depends not only on PaO_2 but also on hemoglobin concentration, efforts should be made to maintain hemoglobin within 12-14 Gm/100 ml of blood.

Use of diuretics[7,14] and salt poor albumin[7] may also help reduce the QS/QT and thus ensure good oxygenation. Maintenance of adequate nutrition and muscle strength of the patient will facilitate weaning the patient off the ventilator.

(Continued)

Use of strict sterile techniques for the care of endotracheal or tracheostomy tube and the equipment used in ventilatory care will help avoid the possibility of pulmonary infection.

The therapeutic measures needed for the care of patients with PTPI are summarized in Table II.

Summary

The characteristic features of post traumatic pulmonary insufficiency are presented and the possible role of Community Hospitals in the care of such patients is mentioned. Two cases are described showing the clinical picture and the management of PTPI. In the end, a brief review of the patho physiology and clinical management of PTPI is presented.

Acknowledgements

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Table II

Goals of Therapy

1. PaO_2 of over 60 mmHg on FiO_2 of 0.4
2. $PaCO_2$ of 30 - 45 mmHg
3. Urine output of 30 - 50 ml/hr
4. CVP of 10 - 15 cm #20
5. PA pressure of 20 -25 mmHg
6. CWP of 10 - 12 mmHg
7. Cardiac Index of over 3.5 L/sq.m/min.
8. Hct. of 30 - 40%
9. Serum Proteins of 6 - 8 gm
10. Serum osmolality of 275 - 300 m Osm.
11. Body Temp. not exceeding 100°F.

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Medieval Medicine and Magic

By George E. McKeever, MD, Dearborn

Casual acquaintance with medieval history and with Byzantium leads superficial observers to the conclusion that these were the "dark ages" of a priest-ridden, superstitious society. The popular hagiography is a literary equivalent of the cult of the relic, the icon and the miracle. However, as the hagiographer relates the circumstances of the miracle, he frames the miracle with a "surround" of factual background material. The historian is thus provided with a primary source for the mundane events of the people under consideration.

Magic has existed since man first formulated ideas. In this paper, I shall attempt to discuss magic as an influence on medicine particularly in the medieval era.

We are able to trace and study some origins of prehistoric medical thought in the aboriginal peoples living in the world. This has been done extensively by Sir James Frazer and recorded in *The Golden Bough*. Frazer states:

"Primitive, prehistoric man conceived the world as a place worked by supernatural agents which were personal beings acting on impulses and motives like his own. These agents were liable, like himself, to be moved by appeals to their pity, their hopes, and their fears."[1] Just as natural forces such as thunder, lightning and rain were thought of as personified gods, the vital functions of reproduction, birth, growth and death were felt to be under their influence as well. Any deviation from the normal expectations learned thru past experience would be considered a result of a loss of favor of a benevolent god or, worse still, the active workings of a malignant spirit, force or demon.

Instinct for Control

Man has an instinct for control which he exploits to advantage on his fellow man; the result if society. Control of animals is known as domestication, and control of plants results in agriculture. There remain natural forces beyond man's control but his pursuit of them continues. Since primitive man does not distinguish between the natural and the supernatural as is commonly done by more advanced peoples it follows that he attempts to control his spiritual as well as his physical environment.

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Frazer wrote ". . . savage man has [also] a different, and probably still older, conception in which we may detect a germ of natural law or a view of nature as a series of events occurring in an invariable order without the intervention of personal agency. That germ is involved in that sympathetic magic which plays a large part in most systems of superstition."[1] Magicians, of necessity, become very good observers of nature and are able to exploit their fund of observations to support the impression of effectiveness of their magical practices on the credulous. Rainmakers are reluctant to perform their art in circumstances where the imminent fall of rain is unlikely. As a consequence the successful rainmaker is usually an astute observer of weather and climatological conditions conducive to rain; he knows when his magic is most powerful. The magician times his efforts to take advantage of the sequence of natural events. In short, he calls for rain at the advent or onset of the rainy season.

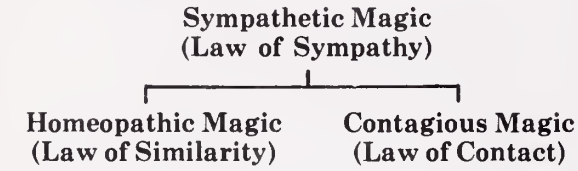
Since primitive man views all events as being under the influence of the will of some personal force, he feels himself vulnerable to these forces as well. The individual learns that illness is a result of an ill will. He knows, as part of his culture, that the magical influence which has caused his illness or bad luck can be offset or counterbalanced by a competent magician. This knowledge is reinforced over the generations by endless demonstrations of improvements which have occurred following recourse to the magician or medicine man. Just as the rainmaker may become a "weatherman," the witch doctor may become a skillful healer. The latter's magic is strongest against nervous afflictions. The core of treatment consists of incubation, rest and confidence-building activities. This triad of treatment is actually one of the common denominators of all healing cults including modern, scientific medicine.

Repeated demonstrations of rainmaking and of magical healings solidify these observations into accepted belief, or superstition. We define superstition as an irrational abject attitude of mind toward the supernatural, nature or God resulting from false beliefs, conceptions or fears.[2]

(Continued)

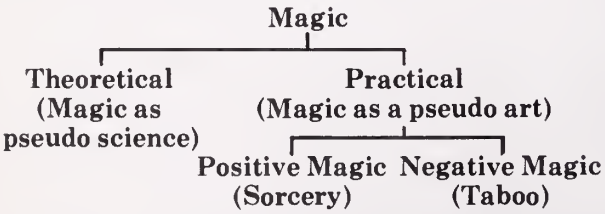
Pragmatic Methods

The mind of man has developed pragmatic methods which direct and control his world of society, animal husbandry and agriculture. Where physical means fail or are obviously inadequate to cope with a supernatural task or problem, he resorts to the superstitious belief in the use of sympathetic magic. To quote Frazer again, "Sympathetic Magic assumes that things act on each other at a distance through a secret sympathy, the impulse being transmitted from one to the other by means of what we may conceive of as a kind of invisible ether, not unlike that which is postulated by modern science for a precisely similar purpose, namely, to explain how things can physically affect each other through a space which appears to be empty." These are visualized by Frazer according to the diagram.



Frazer continues, "Homeopathic magic commits the mistake of assuming that things which resemble each other are the same. Contagious magic commits the mistake of assuming that things which have once been in contact with each other are always in contact."[1(p54)] The two principles are frequently involved simultaneously.

Again from Frazer, "The magician believes implicitly that these same principles which he applies in the practice of his art [also] regulate the operations of inanimate nature. He assumes that the Laws of Similarity and of Contact are of universal application and are not limited to human actions. In short, Magic is a spurious system of natural law as well as a fallacious guide of conduct; it is a false science as well as an abortive art."[1(p53)] This can be illustrated as follows:



The magician, the operator, is concerned only with the practical side of magic.[1(p115)] However, thinking types of men ponder the visible and invisible world at the theoretical end of magic. There may be overlappings of theoretical magic with rational scientific thought. At this extremity, a superstition (*planetary motion is perfectly circular*) is dignified by the term "intellectual scientific paradigm." Destruction of such a paradigm frequently requires something akin to theoretical magic, as Kepler's "Harmony of the Spheres"[3] to form a new more satisfying paradigm.

Frazer concluded, "As time goes on the fallacy of magic becomes more and more apparent to the acuter minds and is slowly displaced by religion; in other words, the magician gives way to the priest, who, renouncing the attempt to control directly the processes of nature for the good of man, seeks to attain the same end indirectly by appealing to the gods to do for him what he no longer fancies he can do for himself."[1(p372)]

Demons as Agents

The antithesis of the priest is one who attempts to control nature by the use of demons as agents, rather than by his own magical power. This is definitely a second rate activity since a real magician requires some talent but anyone can contract the services of a demon.

Sarton has written, "Rationalism and religion are not mutually exclusive; rationalism and superstition are, but it is sometimes difficult to draw a line between superstition and religion."[4(p194)] We would suggest that a superstition is a fixed belief which is accepted or rejected. Religion can be modified by rationalization. In the case of revealed religion, our rationalization must start with the revealed corpus and develop the remainder by deductive, *a priori* reasoning. Christianity was never, and could never be, a philosophy because of the revealed corpus of the Old and the New Testaments. However, the canon and dogma are susceptible to rational inquiry.

Something happened at the beginning of the second half of the first millenium before Christ that was to change man's technique of thinking. The Ionian Greeks invented a new approach thinking.[4(pix)] This has been expressed by the single word in Greek, *logos*. However, I feel that the English word, reason, expresses the idea better in our language since *logos* can have many complex meanings.

The fifth century B. C. was the epoch of rationalism introduced by the Greek philosophers. However, Sarton wrote: "All the sects [of Greek philosophy] except the Epicureans accepted the reality of Magic. . . . The immense difference between Plato and Epicuros consists in this very fact, that the former was ready to exploit popular ignorance and credulity, while Epicuros did his best to eradicate them. For example, Epicuros did not hesitate to reject the whole of divination, and divination was big business."[4(p592)]

The Greek philosophers escalated human thought to a higher plane among the few. The vast majority continued in the old ways of belief and thinking. The fact that most of the rational philosophers accepted magic is an interesting

aspect of the mind which could be termed compartmentalization or a schizoid quality of mind. The individual man can think about different subjects in different ways; love, for instance, is usually irrational.

Hippocrates applied the invention of reason to the discipline of medicine. He was contemporary with the Greek philosophers of the Golden Age. To quote Sarton again:

> We may assume that the youth of the Hippocratic school in Cos coincided with that half century of peace between the Greek naval victory over the Persians at Mycale in 479 B.C. and the beginning of the Poleponnesian war. Hippocrates and other Asclepiads left Cos and spent their lives as wandering exiles. This explains the paradox that the Hippocratic teachings were formulated largely outside of Cos. It may explain another paradox, the persistence of Hippocratic positivism in spite of the Asclepiadic heritage. No matter how strong and pervasive the influence of Asclepios was, the Hippocratic doctors escaped it; instead of their allowing themselves to be subverted by magic rites the opposite happened.[4(p385)]

Hippocratic writings are a'most exclusively lay and rational, with few traces of superstition and hardly any reference to religion. He used the new logic to scientifically study the problems of medicine by the use of inductive, *a posteriori,* reasoning. We would stress that this breakthrough of reason involved only a few persons for a long period of time. Eventually the seed took root and grew so that scientific medicine became universally available.

Faith Healing Prospers

In spite of the revolution in thought, previous concepts and systems of healing continued to exist and to prosper. The ruins of the Asclepieion of Cos are thought to date from the third century B.C., perhaps on the site of a pre-existing one. This cult of faith healing prospered before, during, and after Hippocrates. The cult apparently derived some reflected glory from the Hippocratic school at Cos. This is perhaps the first example in a recurring and persistent series of the co-existence in a community of scientific Medicine and the magical practices of healing.

One of the fruits of the Hippocratic approach to Medicine was the demonstration of nature's healing force, *vis medicatrix naturae,* which recognizes an innate capacity of living things to return to a normal state when displaced from equilibrium through sickness or injury. Neuburger has written:

> While the medical literature of the old Orient knew only healing through the effect of drugs and surgical agents, the occurrence of *spontaneous healing* is established in the *Hippocratic collection* as a fact for the first time, and the *self help of the organism in morbid disturbances* is elevated to an assumption for all medical thinking and all rational therapeutic procedures. With this basic conception and knowledge, which forms a dividing wall between theurgic-empiric and scientific medicine, the Corpus Hippocraticum is permeated by the *idea of natural healing processes* so far as one can express the spirit of the Coic school. For generations this school had cultivated observations of the course of disease and, in alliance with methods of treatment adverse to any polypragmasia, a view had gradually developed that diseases, as all other natural events, are subject to a certain regularity and temporal bond, and that *the organism does not behave passively toward injuries received, but strives to equalize these through self-regulation, and that the symptomatic picture is composed of signs of damage and of defense which can uniquely serve as a directing line for therapy and prognosis.*[5]

To recapitulate thus far, in the evolution of society and of medicine, man was fortunately endowed with a natural tendency to heal, to recover, and survive. A gifted few attempted to improve upon, and in most instances to capitalize on, the healing force of nature. The methods employed were the use of sympathetic magic supplemented by an instinctive use of incubation, rest and confidence. Hippocrates added the capstone of reason and the intellectual structure of modern medicine was complete; scientific medicine was practiced by the few in the Golden Age of Greece in the fifth century B.C.

In the turmoils of the next thousand years, Greek scientific medicine vanished along with the rest of Greek reason. However, the seed remained and was preserved in manuscript form and less well in an oral tradition. Hippocrates was the creator of scientific medical literature and clinical archives. Sarton has pointed out that quality case reports were next written by the Florentine Antonio Benivieni *(d. 1502),* but the interval between the two was almost two millennia.[4(p345)]

East of the Aegean Sea the mind of man gave birth to a different species of thought: the mystery religions of the sixth century B.C. Buddhism, Zoroastrianism and Judaism emerged almost simultaneously. Christianity began with our era as an eastern mystery religion with some distinctive features. First, the religion was founded by an historic person. Second, Christianity held that matter had been sanctified and redeemed by the sacrifice of Christ. The practical point, for our purposes, is that the material, mortal remains of saints were sanctified.

(Continued)

Cult of Relics

Superstitious magical beliefs were combined with Christian attitudes toward the dead and a synthesis resulted in a cult of relics. The magical power of relics became one of the distinctive features of medieval Christianity. The law of supply and demand would render relics unavailable to all except a priviledged few. The desire for some tangible object of faith by the masses resulted in the icon industry. The Byzantines ascribed a new importance to icons following the death of Justinian in 565. The tumultuous times and insecurity fostered an increased religious fervor and the cult of the icon grew.

Hagiography is a literary genre developed by the Byzantines. We could view this as a literary equivalent of the cult of the icon. Magoulias writes, "To understand the Byzantine mind, we must accept the miracle, accounts of magic, etc., simply because the Byzantines did so."[6] These writings cannot be compared to the clinical case reports of Hippocrates which were of a different class of literature. The cases cited in the hagiographic literature resemble quack writings which boast of superiority of methods and results and never admit of failure, and are hypercritical of the competition. However, in the absence of other records, these hagiographic texts provide a window through which to catch a glimpse of the regular practice of medicine which had coexisted in the same times and places with magical healing. Some may conclude, without reflection, from hagiography that magic was the norm of Byzantine medicine. On the contrary, Magoulias has abstracted from the hagiographic texts a fairly clear picture of the hospital practice of medicine which was not unlike our own modern hospital practice. Granted, there was a strong religious tone; but in the modern hospital the priest continues to make his rounds as well as the physician. An interesting phenomenon was the existence of the *philoponoi,* a voluntary organization for the care of the sick. This may be compared, in some degree, to modern hospital volunteer workers, such as the Gray Ladies.

In a later paper Magoulias wrote on hagiography as a vehicle to study magical phenomena of Byzantium. Sorcery was an ever-present threat and sorcerers were treated severely. As Magoulias states, "Sorcerers . . . were as great a menace to the public weal as the murderer and the seditionist; as such they were subject to the same extreme penalty: capital punishment. Saints, in-being able to overcome the evil power of magicians, were regarded by some as superior magicians." Magoulias concluded, "In the eyes of the faithful, the image was identified with its model whose habitation it was. They believed that the icon was indwelt in some mysterious way by the presence of the saint."[7]

Tales of Healing

The writings of Gregory of Tours tell us that hagiography and the cult of the icon and other magical beliefs were not a monopoly of the Byzantines. Loren MacKinney has written that the tales of healing ascribed to the saints contain many references to the regular medical practice.[8] This latter was conducted by the *medici.* The most important physician was the *archiatri,* the royal court physician, a title formerly used for Roman imperial physicians. Below the medici were the *harioli* to whom the populace resorted. The latter used sorcery and secret potions. This reference again demonstrates the local availability of healing at two different levels: rational and irrational.

Byzantium viewed the church and the state as being coextensive and inseparable. In the west a different and complex process of evolution was underway. This was a fragmentation of empire into eventual nation states. The role of "ruler" had been usurped in the west by the pope. In the subsequent ideological struggle a secularization of thought was developed to support the role of magical dynastic kingship. One of the props of the magical king was the acknowledged royal gift of healing. This gift was exercised in touching for the king's evil and in the blessing of cramp rings.[9] Here we see magical healing used to the political purpose of dramatizing the magical character of dynastic kingship.

Faith healing continues. Healing shrines remain busy. The Christian Science Church continues to prosper and grow. The modern man usually fails to discriminate between rational and magical healing. He seeks only for cure, and frequently employs both routes simultaneously. The pilgrims to Lourdes are frequently under rational scientific medical supervision and medication. The patients in the modern medical centers are frequently wearing various charms such as arthritis bracelets, red ropes, amulets.

We have discussed the evolution of medical thought from prehistoric beginnings to the apogee of Hippocrates. Magic was present from the beginning and continues as a variable quantity. Humans usually find the magical and the wonderful to be more interesting and diverting than the practical and mundane. As a consequence, writers are more apt to write of the extraordinary. A writer may present the ordinary as a foil for his miracle writings (*hagiography*). The historian looks to the foil to gain a view of the ordinary events of an era. A superficial reader may see only the miracles described and conclude that the more important, relevant, logical and rational activities were minimal or absent. The Byzantines had faith in miracles and magic; and so do we in muted strength.

(Continued on Page 555)

Clinical Correlates Of Electronystagmography

By Keith M. Holmes, MD, FACS, and Larry J. Byle, MA, Pontiac

Introduction

Electronystagmography has been used as a clinical tool for a number of years. Its popularity can be attested to by the relative proliferation of ENG recording devices on the market, as well as the growing number of trained ENG technicians. This paper will attempt to show the clinical correlation of electronystagmography in an otological practice. The ENG test results will be compared with pre-ENG otologic impressions and audiologic examination.

Procedure

During a two year period (1970-72) 145 patients, consisting of 93 females and 52 males with an age range of 6-87 years, underwent electronystagmographic examination.

The usual symptoms reported by the patients undergoing the examination were those of vertigo, dizziness, ataxia, lightheadedness, falling and feelings of drunkeness or giddiness. Other symptoms including tinnitis, hearing loss and fullness or pressure in the head were reported in a number of cases. Neurological symptomatology such as loss of consciousness, blacking out, convulsive disorders, paresthesis, head trauma, etc., were noted.

All patients underwent routine examinations of the head and neck. Pure tone audiometric threshold examinations were also administered to each patient and in some selected cases special audiometric procedures to determine site of lesion were done. Polytomography was ordered in selected patients and in some cases a neurological consultation was requested. The ENG examination included testing of gaze nystagmus, optokinetic nystagmus, positional nystagmus, the Hallpike test for benign paroxysmal postural vertigo and a bi-thermal water caloric examination.

The test results were interpreted after measuring the caloric nystagmus (maximum speed of slow phase) and then mathematically determining the percentage of directional perponderance or caloric weakness. All findings were discussed by the technician and the examining physician prior to the institution of therapy.

The principal diagnoses entertained before ENG examination were: benign paroxysmal postural vertigo, Meniere's disease, vestibular neuronitis, vascular disorders, central nervous system disease and trauma. Some less common abnormalities where ENG was performed were periarteritis nodosa, labyrinthine, otosclerosis, motion sickness, multiple sclerosis and neurological labyrinthine abnormalities.

(Continued)

Table I

The number of male and female patients with normal neurosensory, or conductive hearing losses receiving normal, peripheral, central, non-specific or BPPV ENG test results.

ENG Findings	Number	Normal	Neurosensory	Conductive	Male	Female
Normal Results	71	36	33	2	24	47
Peripheral Vestibular	39	8	30	1	15	24
Central Vestibular	3	2	1	0	1	2
Non-specific	31	16	14	1	11	20
B.P.P.V.	1	1	0	0	1	0

The ENG test results fell within five basic categories:

1. Normal examinations.
2. Peripheral vestibular abnormalities.
3. Central vestibular abnormalities.
4. Non-specific abnormalities.
5. Benign paroxysmal postural vertigo.

In order to be classified in the latter category the patient had to exhibit all four findings of the classical Hallpike test. These findings are: a burst of Nystagmus accompanied by vertigo following a short latency period and fatigability on repeated trials.

Results and Discussion

Table I presents the ENG test results as compared with the audiometric results. Nearly one half of the patients in the study had no significant abnormalities on their ENG examination, but of the normal group the audiometric results were nearly evenly divided between normal hearing patients and those with neurosensory hearing losses. Patients with abnormalities affecting the peripheral vestibular system as determined by the ENG made up the only group where the audiometric results appeared to follow a certain pattern; of 39 patients in this group, 30 had neurosensory hearing losses. The non-specific abnormalities were almost evenly distributed between normal hearing patients and those with neurosensory hearing losses. The remaining groups had too few numbers in them to formulate any comparisons between the ENG results and the audiometric findings.

Table II shows a comparison between the medical impression pre-ENG and the ENG test results. The medical impression was based on the patient case history, audiometric findings, and head and neck examination.

The patients having a pre-test impression of Meniere's disease accounted for the greatest number in any of the groups. Fifty-seven of these patients, nearly half of the total, exhibited normal ENG test results. The other half of the suspected Meniere's patients demonstrated a near equal number of ENG results in the peripheral vestibular and non-specific categories. Vascular abnormalities, vestibular neuronitis and BPPV also showed the greatest number of patients with normal ENG examinations. The trauma group, however, demonstrated more peripheral vestibular abnormality results on the ENG examination than any other category. Even in the trauma category however, the number of patients having normal ENG results was nearly one third of the total number for that group. The other categories of pre-test impressions did not contain enough patients to draw any conclusions.

The ENG results when compared to the audiologic findings showed that abnormalities of the peripheral vestibular system most often were accompanied by a neurosensory hearing loss. The patients with normal ENG examinations were nearly evenly divided between those with normal hearing tests and those with neurosensory hearing losses. It should be noted, however, that many of the neurosensory hearing losses seen on patients in the study were that of either acoustic trauma or presbycusis and probably not associated with the vestibular abnormality.

Table II

The number of patients having otologic diagnositc impressions of Meniere's, vascular, vestibular neuronitis, trauma, BPPV, central or misc. disorders with normal, peripheral, non-specific, central, or BPPV ENG test results.

ENG Findings	Meniere's	Vascular	Vestibular Neuronitis	Trauma	B.P.P.V.	Central	Misc.
Normal	28	20	8	4	7	1	3
Peripheral	16	5	3	7	2	3	3
Non-specific	12	7	6	2	3	0	1
Central	0	0	1	0	1	1	0
B.P.P.V.	1	0	0	0	0	0	0

Summary

One-hundred forty-five patients were seen for electronystagmographic examination during a two year period. These patients were administered the examination after the otologic and audiologic work-up. This paper makes a comparison between the ENG test results, the audiologic findings and the pre-test medical impression.

Normal ENG findings outnumbered abnormal findings in most categories.

The ENG as a diagnositc tool in postural dizziness as well as central nervous system vascular disease would appear to have limited value. Again, other information including the patient's age, occurence of symptoms and radiographic findings, as well as history of past disease, would seem to be more important than the electronystagmography tracings.

Electronystagmography even when normal does tend to shed light on the cases with diagnositc difficulty. It can be likened to the electroencephalogram (EEG) in that it can be used as a broad screening tool, however, its specificity is of limited value. Electronystagmography has helped to crystalize and clarify our thinking regarding "the garden variety" dizzy patient that the practitioner and specialist in otolaryngology sees daily in his practice.

It has obviated the use of the ice water caloric test entirely from our practice. It has been found to be more reliable, objective and uniform in its interpretation. In addition, one has a permanent tracing and a baseline study of the initial condition. Furthermore, patient discomfort is limited with this testing technique as opposed to the rather uncomfortable, variable and sometimes distressing symptoms produced by the ice water caloric test. We feel that the limitations are few in office practice, and, short of space limitations and the initial expense, it is a readily available laboratory device for use in office applications.

Electronystagmography examination is not especially helpful in making a diagnosis of Meniere's disease. The history combined with follow up audiologic evaluation would appear to be of more diagnostic value in this condition. It should be added that none of the patients was tested during an acute attack of Meniere's disease. Had this been done, perhaps more positive test results would have been obtained.

Patients demonstrating unilateral neurosensory hearing loss had both polytomographic x-ray studies and selective audiologic evaluation to determine site of lesion.

Electronystagmography has shown itself to be of value in assessing peripheral vestibular abnormalities in cases of head trauma. In this regard it is of significance in the medico-legal area and workmen's compensation cases.

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HMO Law Passes

Legislature Sets up Rules for Operation of Prepaid Group Contract Medical Practice

By Bruce Ambrose, Manager, MSMS Department of Government Relations

Health maintenance organizations (prepaid group contract practice) will be licensed and regulated by the state under legislation enacted by the recently-recessed Michigan Legislature.

The Legislature recessed until Sept. 17, when a two or three week fall session is scheduled.

Put forth as a bill to assure quality control of health care services in HMOs, and financial soundness in prepayment plans, the measure also requires consumer input through representation on boards or committees.

An HMO may be either non-profit or proprietary.

HMOs may either contract with physicians on a full-time, salaried basis, or via fee-for-service and/or part-time basis.

A three-step phase-in of services is permitted. An HMO will first receive a license under which it must provide "primary" health maintenance services; upon renewal of its license after three years, the benefit package must be expanded to "basic" services. Also upon first renewal of the license, the HMO must offer, at an adjusted price, "supplemental services" on an optional basis.

The Director of the Department of Public Health shall issue the license, but only after the Insurance Commissioner has approved the financial plan of the HMO. There will be a Health Maintenance Organization Commission of seven persons, appointed by the Governor, as an appeal and guidance body.

A health maintenance organization is described as a legal entity which:

(a) Delivers health maintenance services to enrollees under the terms of its health maintenance contract, directly or through arrangements with affiliated providers.

(b) Is responsible for the availability, accessibility and quality of the health maintenance services provided. Within the area served by the health maintenance organization, the services shall be available, accessible and provided promptly as appropriate to each of its enrollees in a manner which assures continuity, and be available and accessible to enrollees 24 hours a day and seven days a week for the treatment of emergency episodes of illness or injury.

Types and Form of Health Coverage

Primary health maintenance services means:

(a) Physician services including consultant and referral services by a physician, but not including psychiatric services.

(b) Ambulatory services.

(c) Inpatient and outpatient hospital services, other than those for the treatment of mental illness.

(d) Emergency health services.

(e) Diagnostic laboratory and diagnostic and therapeutic radiologic services.

(f) Preventive health services.

These primary health services must be offered, as a minimum, during the initial three year license period.

Basic health services means:

(a) Physician services including consultant and referral services by a physician, but not including psychiatric services.

(b) Ambulatory services.

(c) Inpatient and outpatient hospital services, other than those for the treatment of mental illness, not covered by this section.

(d) Emergency health services.

(e) Short-term, not to exceed 20 visits, outpatient evaluative and crisis intervention mental health services and treatment or referral for treatment for the abuse of or addiction to alcohol, drugs and controlled substances.

(f) Diagnostic laboratory and diagnostic and therapeutic radiologic services.

(g) Home health services.

(h) Preventive health services.

These basic health services must be offered, as a minimum after the date of the first renewal of an HMO license. In other words, after three years an HMO must add (e) and (g) listed above to its coverage.

Supplemental health services means:

(a) Services of licensed facilities for intermediate and long-term care.

(b) Vision care, including optometric service.

(c) Dental services.

(d) Mental health services not included in the basic health services.

(e) Long-term physical medicine and rehabilitative services including physical therapy.

(f) Clinical pharmacy services or prescription drugs prescribed in the course of the provision of a basic health service or a service described in other sections.

(g) Chiropractic services.

(Note: When vision care services are offered as a health maintenance service under this act, the health maintenance organization shall include optometric services, as an option to subscribers.)

Three years after the initial license is issued, a health maintenance organization shall offer the SUPPLEMENTAL HEALTH SERVICES as separate or combined options to subscribers for such additional payment as the health maintenance organization requires. This requirement shall be waived if the health maintenance organization demonstrates, to the satisfaction of the director and the commissioner, that the provision of supplemental health benefits, under this section would tend to endanger the financial stability of the health maintenance organization, that manpower or other resources are not available in the area served by the health maintenance organization to adequately provide such services, or that the option would not be exercised by enough subscribers to economically justify its provision. (Here again after three years of operation an HMO is expected to offer optional supplemental services at an increased cost to the subscriber. As noted an HMO may be exempted from this supplemental provision.)

Other Provisions

A health maintenance organization may contract with or directly engage physicians, chiropractors, nurses, optometrists and other health professionals or affiliated providers to render the services the organization has agreed to provide under the terms of its health maintenance contracts.

Health maintenance organizations may provide additional health maintenance services, including dental, pharmaceutical and clinical pharmacy services, nutrition services, hearing services, mental health, vision, home health, rehabilitation, nursing home care, health education, and any other care, service or treatment not required under this act.

In cases of emergency episodes which require immediate treatment before treatment could be secured through the health maintenance organization, an enrollee may utilize a provider within or without the state not normally engaged by the health maintenance organization. Payment of reasonable expenses or fees is required.

A contract shall be deemed to be between the health maintenance organization and the subscriber. The contract may be supplemented by additional nominal payments which may be required for the provision of specific health maintenance services.

A health maintenance organization shall establish and maintain reasonable procedures for receiving, processing, and resolving enrollee grievances relating to the operations of the organization.

The patient on uricosurics: another type for Tylenol (acetaminophen)

When the patient on uricosuric therapy requires an analgesic, a new problem arises. Aspirin in the usual analgesic doses inhibits the action of uricosurics.[1,2]

TYLENOL (acetaminophen), on the other hand, causes no appreciable uricosuric antagonism[2] and for this reason is preferred over aspirin in the gout patient.

This is only one of several 'types for TYLENOL'—that is, patients who should avoid aspirin. Considering all of them, wouldn't it provide added safety (as well as added convenience) to recommend TYLENOL (acetaminophen) routinely for simple analgesia?

References: 1. Martin, E.W., et al., ed.: Hazards of Medication, Philadelphia, J.B. Lippincott Co., 1971, p. 511. **2.** Seegmiller, J.E.: Med. Clin. North Amer. 45:1259-1272 (Sept.) 1961.

Precautions and Adverse Reactions: If a rare sensitivity reaction occurs, the drug should be stopped. TYLENOL (acetaminophen) has rarely been found to produce any side effects.

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Commentary

Bad Apples

By John G. Slevin, MD, Grosse Pointe Park

The legal profession, according to reports from the American Bar Association, is concerned with the public's view that its professional image is tarnished. We too, in medicine, must be concerned about our poor image that a few bad apples give us.

Every professional group, including law and medicine, has had and probably will continue to have a few members whose actions reflect unfavorably upon the group, human nature being what it is. However, the increasing number of lawyers and physicians who run counter to the law, places both professions much in the limelight by unfavorable publicity.

We ask, what has happened to degrade these two noble professions' esteem in the minds of the public? We believe it reflects the general decay of our national morals. Situational ethic has replaced the absolutes of right and wrong which heretofore dominated our life style. Moral rectitude has given way to the notion that anything goes if you can get away with it. Watergate is just the festering sore which surfaced from such moral turpitude. It is a dangerous symptom in our body politic. It is well that both professions are cognizant of the problem and ready to take remedial measures to correct it.

Unnecessary Procedures

A few physicians have bilked Blue Shield by performing hundreds of procedures where the records indicate most MDs do less than a dozen a year. Moreover, we cannot justify the charges of a few that are two or three times the usual and customary fees of their colleagues for the same operation. These people are the bad apples in the medical barrel. They reflect most unfavorably upon all of us.

We in medicine pride ourselves on policing our own. Are we doing it? Are we really being hard nosed in dealing with our bad apples? If a man is barred from practice in a hospital because of wrong doing, does the chief of staff notify other hospitals and the medical society so that Doctor "Joe Doaks" cannot go elsewhere to practice bad medicine? Of course we don't! We are afraid Doctor Joe will sue us for libel.

If we really mean to clean the few bad apples out of the medical barrel, we **must** bring the culprits to justice. That means being willing to face a libel suit. If we are right that Doctor "Joe D." practices

Dr. Slevin

bad medicine, charges exhorbitant fees, does unnecessary surgery for financial gain or commits other unethical or dangerous acts, he should be exposed. He won't press his libel suit. The last thing he wants is public exposure of his nefarious acts.

The medical profession, like the legal profession, must have the "guts" to weed out the bad apples "pro bono publico!"

Postscript

After further consideration it seems to me I should emphasize that the new Medical Practice Act in force since Jan. 1, 1974, provides a disciplinary means not previously available to medical staffs or county society ethics committees. Hence, this postscript is meant to inform all concerned of the new powers granted to the Medical Board of Registration.

The new law gives the Medical Board, after due legal process, the right to put a recalcitrant physician on probation; to limit the scope of his practice; to temporarily suspend his license or to revoke his license to practice medicine according to the needs in each case.

Not only can the board do this in the case of the MD who practices "bad" or unethical medicine, inimical to the public. It can also do the same for the "sick physician." By sick physician is meant the MD who is an alcoholic or addicted to drugs or whose mental faculties are impaired so that he is a danger to the public. The board can withhold his license until the "sick physician" is under treatment and declared to be well. If properly used this new law can be a real protection to the public.

So we urge medical staffs and ethics committees to make use of this new tool in the public interest.

Reprinted, by permission, from the Detroit Medical News, July 22 and July 29, 1974.

Michigan Medicine's new Commentary page will offer physicians and others the opportunity to express opinions on issues in medicine. Contributions are invited and should be submitted to Commentary, *Michigan Medicine,* 120 W. Saginaw St., East Lansing, Mich. 48823.

The views expressed here are those of the author and do not represent positions of the Michigan State Medical Society or opinions of the editors of *Michigan Medicine.*

Preventive Actions May Help Avoid Professional Liability Problems

Throughout the land professional liability insurance carriers are announcing substantial premium increases; some are limiting their coverage to lesser risk classifications, and others are withdrawing entirely from writing this category of protection.

MSMS members are experiencing periodic and substantial premium rate increases for this protection which is so essential to the practice of medicine. MSMS offers the following points to physicians.

1. Keep your expired professional liability policies.

The standard two year Statute of Limitations is not applicable to minors or incompetents, or, sometimes, until the malpractice is "discovered."

2. Keep good records and retain them for years.

In any event retain records in *all* cases for a minimum of six (6) years after date of last treatment. As to the special situations presented by minors and the mentally ill or incompetent, see your personal attorney.

3. Advise patients as to risk involved in not only operative procedures, but also as to side effects of drugs prescribed or administered; this is frequently called "Informed Consent."

The legal test appears to be "What would the average prudent person in the patient's position have decided if informed of the perils?" No longer is the legal test what the *physician* believes the patient or his representative should know about the risks of the patient.

4. The "Locality Rule" is under attack.

The specialist, perhaps also the "generalist," can now be subject to liability in an action for negligence if he fails to exercise that degree of care and skill which is exercised by the average practitioner in a class to which he belongs, acting in the same or similar circumstances. Geographical area and its attendant lack of facilities are circumstances that can be considered if appropriate.

5. Continued membership in your society is recognized by the courts as vital for continuing education.

The courts state that there is no lack of opportunity to keep abreast of the advances made in the medical profession and cite *JAMA* as authority. The same reasoning applies to *Michigan Medicine* and to the society's continuing education program as well as to seminars and on-going educational opportunities.

6. Refrain from ill-advised remarks; think before you speak.

Many of the malpractice cases have their genesis in spontaneous statements of a nurse, a technician or a physician. Warn your employees and assistants to be on the alert at *all* times.

7. Give prompt notice to insurer in the event of an "incident."

Should there be any occurrence in the patient-physician relationship which might result in either a claim or litigation, give prompt notice to the carrier. Timely notice and prompt investigation are far superior to waiting for a formal summons.

8. Provide continuity of care.

Once a physician accepts a patient which requires a course of treatment he should pursue the plan of prescribed care. If the physician is to be out of the area for an extended period he should arrange for suitable coverage and so notify the patient. Should the patient fail to complete the prescribed plan of care, the physician should follow-up. In either event this should be documented in the patient's record.

9. Be alert to the suit-prone "litigious" patient.

Some patients have a tendency to be hypercritical of physicians who have previously treated them. Others may have unrealistic expectations of good or perfect results of medical care. In such situations, caution should be exercised to minimize the probability that you or a physician who has treated the patient previously will become involved in a liability claim or suit.

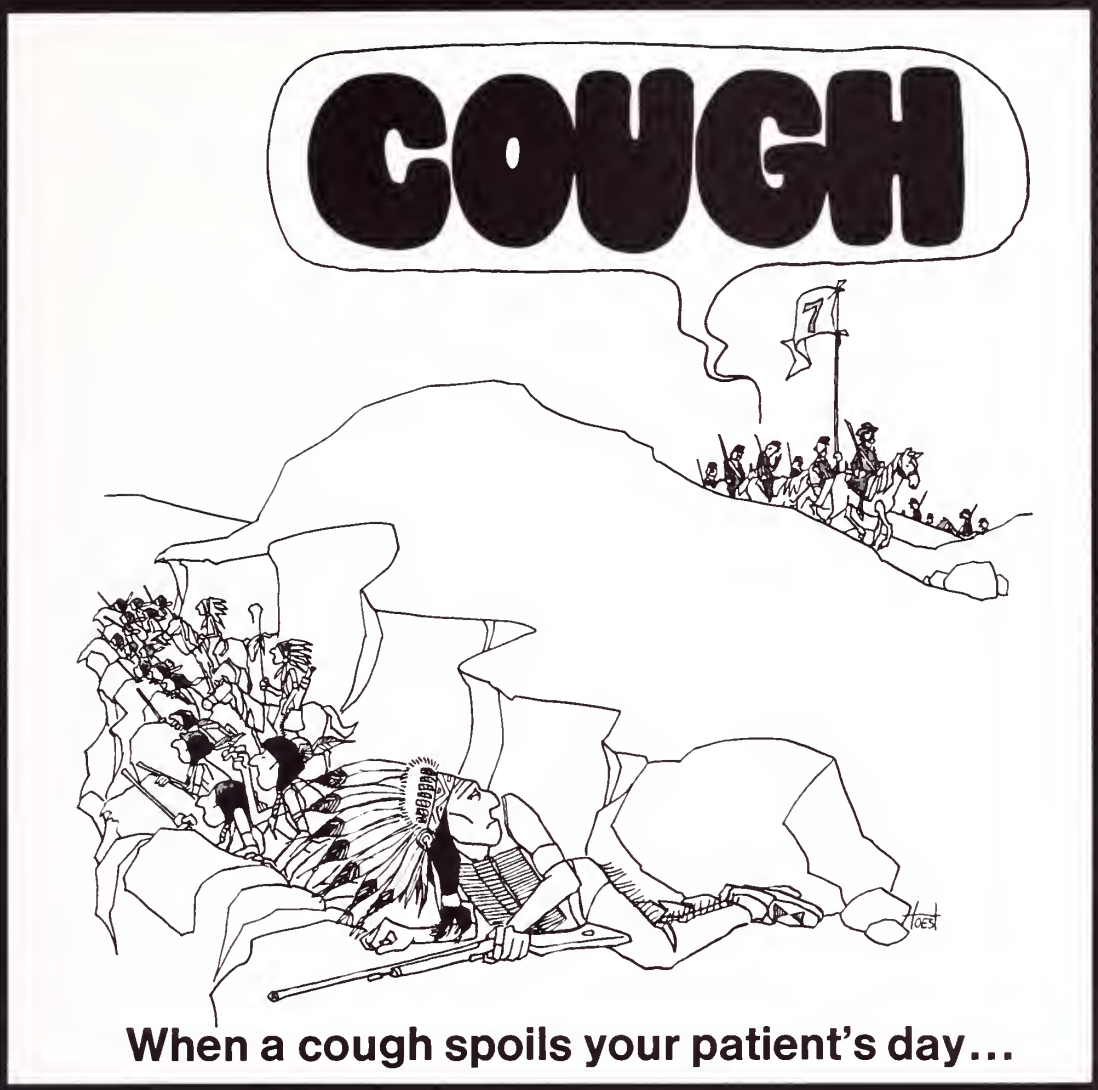
10. Avoid discussion of your liability insurance.

The knowledge that you carry insurance *may* precipitate a claim should an unanticipated complication arise or if the patient becomes dissatisfied with the results of a course of treatment.

11. Always exercise discretion in the collection of accounts.

Turning a delinquent account over to a collection agency — especially if there is evidence of patient dissatisfaction, may well be the basis for a counter charge in the form of a suit against the physician. While the physician is entitled to

(Continued on Page 562)



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AMA-ERF Funds Show Increase

The American Medical Association Education and Research Foundation has reported raising $1,250,357 during 1973 for unrestricted distribution to medical schools in the United States. This is an increase of $277,994 over the total raised in 1972.

In the distribution, the following amounts went to schools in Michigan: University of Michigan Medical School, $17,517; Wayne State University School of Medicine, $7,903, and Michigan State University College of Human Medicine, $11,210.

U-M Medical Center Reunion Set for Oct. 11-12

Plans have been announced for the 1974 University of Michigan Medical Center alumni reunion to be held Oct. 11 and 12 in Ann Arbor. A highlight of the program for Friday, Oct. 11, will be a panel discussion on "The Medical Center's Role in Primary Care and Primary Care Training."

The program for Saturday, Oct. 12, includes an alumni picnic at 11 a.m. and the University of Michigan-Michigan State University football game.

remuneration for professional services, foregoing payment may be less of a loss than being a defendant in a lawsuit.

12. Avoid direct contact with a plaintiff's attorney.

In the event of a claim or suit and the plaintiff's attorney attempts to contact you, refer him to your own attorney. Any communication you may have with a plaintiff's attorney — no matter how well intentioned — might very well compromise your defense if the case proceeds to litigation.

Physicians are encouraged to communicate any helpful hints to *Michigan Medicine* so they may be shared with colleagues to serve the public and the profession.

This article was adapted, with permission from material published originally in the* Wisconsin Medical Journal, *by A. Stewart Kerr, MSMS legal counsel.

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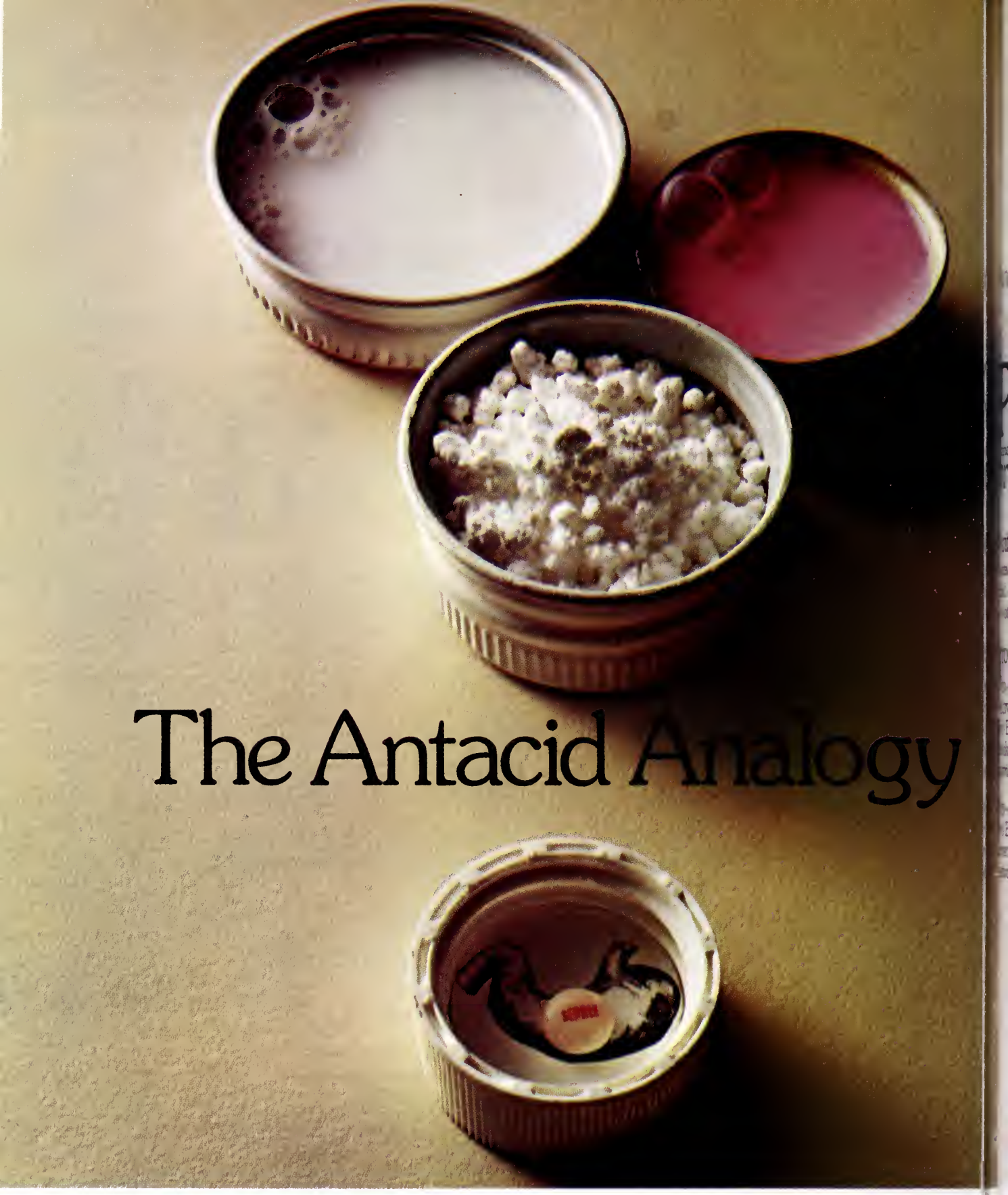

Indications: Pro-Banthine is effective as adjunctive therapy in the treatment of peptic ulcer. Dosage must be adjusted to the individual.

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Warnings: Patients with severe cardiac disease should be given this medication with caution.

Fever and possibly heat stroke may occur due to anhidrosis.

In theory a curare-like action may occur, with loss of voluntary muscle control. For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted.

Diarrhea in an ileostomy patient may indicate obstruction, and its possibility should be considered before administering Pro-Banthine.

Precautions: Since varying degrees of urinary hesitancy may be evident by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions may

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*Innes, I. R., and Nickerson, M., in Goodman, L. S., and Gilman, A. (editors): The Pharmacological Basis of Therapeutics, ed. 4, New York, The Macmillan Company, 1970, p. 537.

Pro-Banthine complements and enhances the action of antacids.

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occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

Dosage and Administration: The recommended daily dosage for adult oral therapy is one 15-mg. tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

Pro-Banthine P.A.—Each tablet of Pro-Banthine P.A. (propantheline bromide) contains 30 mg. of the drug in the form of sustained-release or timed-release beads; on ingestion about half of the drug is released within an hour and the remainder continuously as earlier increments are metabolized. Thus the result is even, high-level anticholinergic activity maintained all day and all night in most patients with only two tablets daily. Some patients may require one tablet every eight hours.

The contraindications and precautions applicable to Pro-Banthine 15 mg. should be observed.

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Opinion & Dialogue

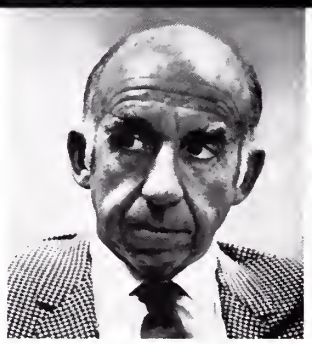
The Role of the Detail Man

Dr. Willard Gobbell
Family Physician
Encino, California

"I may be prejudiced, but I am very much in favor of the detail men I meet. Most of them are knowledgeable about the drugs they promote and can be a great help in acquainting me with new medication."

Family Physician's Perception

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most of the men who visit me regularly and they in turn have become aware of my particular interests and the nature of my practice. They, therefore, limit their discussion as much as possible to the areas of interest to me. Since I usually see the same representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date information about his products.



Dr. Jeremiah Stamler
Chairman
Department of Community Health and Preventive Medicine, and Dingman Professor of Cardiology
Northwestern University Medical School

"In the total picture of dealing with health problems in this country there is a potential for detail men to play a meaningful role."

The Positive Influence

My contact with representatives and salesmen of the pharmaceutical industry is the type of contact that people in a medical center, research people, and academic people have and that's in all likelihoc on a somewhat different level from that of the practicing physician.

Let me touch on how I personally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be—and at times actually are—disseminators of useful information. They could consistently serve a real educational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets—some of it scientifically sound and therefore truly useful—as well as some excellent films produced by the pharmaceutical industry. When they function in this

Is He a Source of Information?

Yes, with certain reservations. The average sales representative has a great fund of information about the drug products he is responsible for. He is usually able to answer most questions fully and intelligently. He can also supply reprints of articles that contain a great deal of information. Here, too, I exercise some caution. I usually accept most of the statements and opinions that I find in the papers and studies which come from the larger teaching facilities. It goes without saying that a physician should also rely on other sources for his information on pharmacology.

Training of Sales Representatives

Ideally, a candidate for the position as a sales representative of a pharmaceutical company should be a graduate pharmacist who has a questioning mind. I don't think this is possible in every case, and so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

---

capacity they are indeed useful; particularly in the fact that they disseminate broadly based educational material and serve not just as "pushers" of their drugs.

The Other Side of the Coin

Obviously, the pharmaceutical companies are not producing all this material as a labor of love—they are in the business of selling products for profit. In this regard the ambitious and improperly motivated sales representative can exert a negative influence on the practicing physician, both by presenting a one-sided picture of his product, and by encouraging the practitioner to depend too heavily on drugs for his total therapy. In these ways, the salesman has often distorted objective reality and undermined his potential role as an educator.

The Industry Responsibility

Since the detail man must be an information resource as well as a representative of his particular pharmaceutical company, he should be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.,* the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

The Foreign Medical Graduate: Two Perspectives

Medical Educator Calls for International Planning

By Leo T. Heywood, MD, Omaha, Neb.

The foreign medical graduate, as an individual (excluding Americans who receive their medical education abroad), has problems which can be considered as "general" in nature and are no different actually than those of any other similar immigrant, whether he is a long-stay visitor or a permanent resident. However, those factors which contribute to the current mass migration of physicians to the United States are creating what could be considered to be "special" problems.

There is a simple way, I suppose, to gain some insight into the general problems of the foreign medical graduate. Picture yourself, the product of an American medical school and of our system of graduate medical education, familiar with only one language, suddenly transplanted into a strange country. You have no concept of national or local customs. You are equipped with an academic knowledge of the language but you have no experience in the vernacular. Your ability to communicate in writing may be even more inadequate. You are confronted with a spectrum of disease somewhat different from what you became familiar with here at home. In addition, you are now asked to function without any concept of the organization and delivery of health services in your new surroundings.

Communication Problems

It is not difficult to imagine what would happen. Certainly, you would feel abandoned, bewildered and depressed. Your ability to communicate with your new colleagues would be seriously jeopardized. You could not escape feeling inadequate professionally when you came to realize that the training you received at home was for management of diseases not commonly found in your new environment. How could you escape becoming somewhat resentful when you became aware that the training program, which was so glowingly represented to you, turned out to be somewhat second-class and not on a par with those which the citizens of your new country were able to obtain. Even more frustrating would be the discovery that what appeared to be a fine educational experience was actually a heavy service-oriented program with little of the expected education component. Surely you would come to realize that the training, or to state it more accurately, the work you were doing, would prepare you for little or nothing of practical value when you returned to the United States. In addition to all of this, you would be constantly subjected to the xenophobia latent in all countries and in all cultures when someone different attempts to operate within their social structure.

This is an abbreviated version of the "general" problems confronting the foreign medical graduate.

We have been made aware of the multiplicity of "special" problems created by mass migrations of foreign physicians into this country. Statistical analyses of what was considered previously questionable accuracy have repeatedly been presented to show us where they come from, where they go, what they do, how long they stay and where they eventually establish a practice. We have been appraised of the effect of the foreign medical graduates on our mode of practice and of our influence on them and of what all this has done to the stature of medicine in other countries. Solutions to the problems created by this activity have been suggested; but to date, little of substance has been accomplished.

If our national policy is such that we are to continue to depend upon the foreign medical graduate to supplement our medical manpower needs, then it would seem to me we ought to get on with the task of correcting the inadequacies that presently exist. It is only human and rational that we begin by devising some means of amalgamating them into our culture in the least traumatic fashion, at least for the length of their stay with us.

Orientation programs must be developed to prepare the foreign visitor with sufficient cultural and linguistic knowledge to satisfy his needs.

Cultural orientation should be structured to

(Continued on Page 573)

Doctor Heywood is a past president of the Federation of State Medical Boards and one of the founders of the FLEX program. His article appeared originally in the Federation Bulletin *and is reprinted with the permission of the Editor,* Federation Bulletin, *Copyright, 1973. The Federation of State Medical Boards of the United States, Inc.*

MSMS Tackles Programs to Aid 3,000 FMGs Practicing Here

By Regina el Arculli, MSMS Staff

Before World War II, American physicians went to Europe to study and catch up with the latest medical techniques. The trend has reversed since. Physicians from all over the world now flock to the United States because of the improvement in technology and facilities which they cannot obtain at home. As the United States did not keep up with its need for doctors until the early 60s, these foreign medical graduates* are an additional source of manpower. Even the U.S. Immigration policies were changed in 1969 to facilitate the immigration of FMGs. At present, FMGs are the only professional people allowed into the United States without restriction.

It may be startling to learn that in Michigan one of every four doctors, or 25.4 per cent of 12,293 MDs, is a foreign medical graduate. Were the FMGs on house staffs of the Detroit hospitals to go on strike, the entire public health care system in that city would collapse. The number of FMGs in Michigan has climbed from 2,376 in 1970 to 3,122 in 1973, an increase of almost 30 per cent in three years. And this trend has shown no sign of abating.

Many Problems

With the migration of so many FMGs from so many diverse countries, cultures and backgrounds, cross-cultural problems abound. Michigan has doctors from 72 countries. Table I prepared from the 1973 master physician information file of the American Medical Association Center for Health Services Research and Development, shows the 10 countries supplying the largest numbers of FMGs to Michigan as of 1973.

Faced with the influx of foreign-trained physicians to the state of Michigan, the Michigan State Medical Society felt it should play a greater role in helping these doctors and their families adjust sooner and easier into their professional and social worlds.

Because of this concern, the MSMS House of Delegates last May by resolution approved a new effort toward assisting FMGs, particularly as they seek full licensure to practice. The resolution called for a committee which would survey the existing population of FMGs and set up educational programs in English and basic sciences to help them prepare for licensure examinations.

The new committee, under the chairmanship of Chi Pang Wen, MD, a Taiwanese associate professor at the Michigan State University College of Human Medicine, already has met several times to map plans for such review sessions. The committee would like to see the first such session scheduled in December.

Committee members along with Doctor Wen are: Jaime Aragones, MD, a Filipino ophthalmologist practicing in Rochester; Alfredo Fleurquin, MD, from Argentina, who is head of the radiation therapy department and the radioisotopes department at Pontiac General Hospital; Shawky Hassan, MD, an Egyptian specialist in allergies practicing in Flint and A. Alberto Hodari, MD, the Argentinian director of the residency program at the Detroit Memorial Hospital.

The resolution, introduced by Doctor Aragones, a delegate from the Oakland County Medical Society, formalized MSMS concerns. A series of recommendations grew out of two workshops held for FMGs in practice in Central Michigan and in the Detroit metropolitan area and in residency training programs.

FMG participants agreed on recommendations directed primarily toward newly arrived residents and interns. They are:

(Continued on Page 577)

* Those who had graduated from medical schools abroad. Thus a U.S. citizen is known as a foreign medical graduate if he attended medical school outside of the United States, Canada or Puerto Rico.

TABLE I

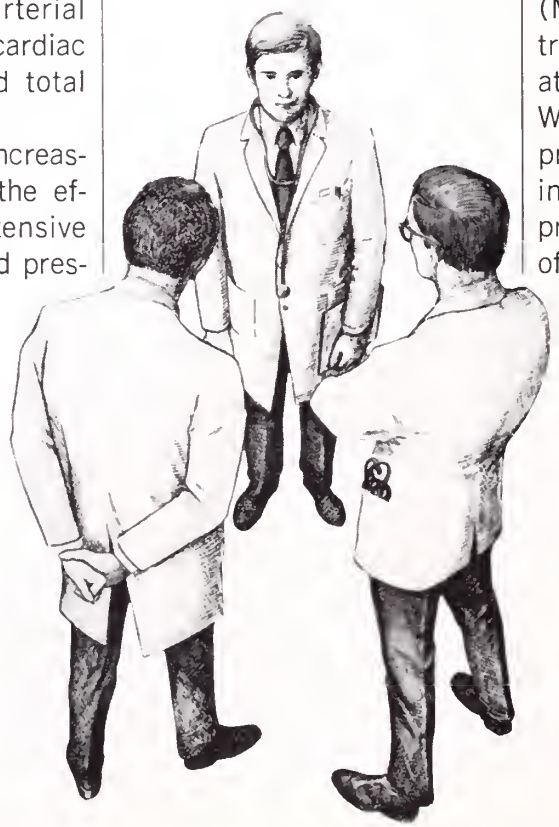
Foreign Countries Contributing Greatest Number of Graduates to Michigan — 1973

Country	Number of Physicians
Philippines	494
India	474
South Korea	196
Iran	172
Germany	156
Thailand	109
Turkey	98
Argentina	83
Pakistan	83
Mexico	68

The more physicians consider the hemodynamics of lowering blood pressure...

Most physicians now agree on the importance of reducing blood pressure in the hypertensive patient. But high blood pressure exists, of course, only as part of a complete clinical picture. The hemodynamic profile of well-established essential hypertension is characterized by elevated arterial blood pressure, normal cardiac output, and increased total peripheral resistance.

And so, physicians are increasingly concerned with the effects of an antihypertensive agent not only on blood pressure itself but also on the hemodynamic pattern—in short, with the total effect of the drug. *Does* it indeed help lower blood pressure effectively? *Is* peripheral resistance reduced? *Are* cardiac output and renal functions maintained? And, also, is there likely to be drug-induced postural hypotension serious enough to pose a threat to the patient's cerebrovascular status?



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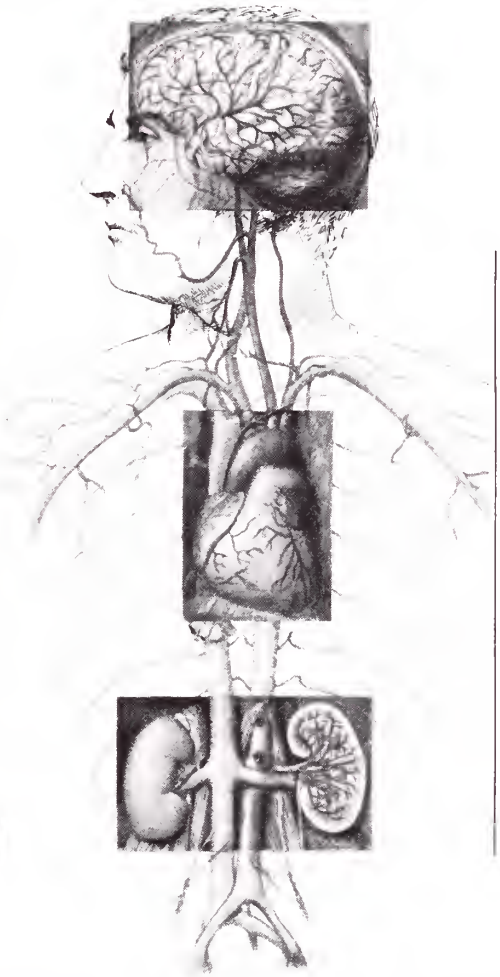
With its unique hemodynamic profile, ALDOMET has drawn increasing attention and approval from physicians. First, of course, for its efficacy in

the more physicians rely on this unique antihypertensive



lowering blood pressure. But there are other considerations as well. Cardiac output is usually maintained with no cardiac acceleration; in some patients the heart rate is actually slowed. Peripheral resistance is apparently reduced. ALDOMET does not usually compromise existing renal function; it generally does not reduce renal blood flow, glomerular filtration rate, or filtration fraction. And ALDOMET usually does not cause symptomatic postural or exercise hypotension.

Contraindications include active hepatic disease and known sensitivity to the drug. Use with caution in patients with a history of liver disease or dysfunction. Not recommended in pheochromocytoma or pregnancy.

It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. For more details see the brief summary of prescribing information.

In most cases of sustained moderate hypertension

TABLETS, 250 mg and 500 mg

ALDOMET®

(METHYLDOPA | MSD)

smoothly lowers blood pressure

NEW now available in **500 mg TABLETS** as well as the standard 250-mg tablets

For a brief summary of prescribing information, please see following page.

In most cases of sustained moderate hypertension

ALDOMET®
(METHYLDOPA MSD)

smoothly lowers blood pressure

Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis. Known sensitivity. Not recommended in pheochromocytoma. Unsuitable in mild or labile hypertension responsive to mild sedation or thiazide therapy. Use cautiously in patients with history of previous liver disease or dysfunction.

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between six and twelve months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at six and twelve months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first three weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first two to three months of therapy. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first six to twelve weeks of therapy or whenever an unexplained fever occurs. If fever, abnormalities in liver function tests, or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, reversible reduction in leukocyte count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur.

Use in Pregnancy and Childbearing Age—Not recommended in pregnancy. In women of childbearing age, weigh potential benefits against possible fetal hazards.

Precautions: Methyldopa may interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, spuriously high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has occurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: Sedation, usually transient, may be seen during initial therapy or when dosage is increased. Headache, asthenia, or weakness may be noted as early, transient symptoms. Symptoms associated with effective lowering of blood pressure are occasionally seen and include dizziness, lightheadedness, and symptoms of cerebrovascular insufficiency. Angina pectoris may be aggravated. Symptoms of orthostatic hypotension may occur; if symptoms occur, reduction of dosage is suggested. Bradycardia, nasal stuffiness, mild dryness of mouth, and gastrointestinal symptoms including distention, constipation, flatus, and diarrhea occur occasionally; these generally can be relieved by reducing dosage. Nausea and vomiting have been reported in only a few patients. Sore tongue or "black tongue," pancreatitis, and inflammation of salivary glands may occur.

Weight gain and edema occur infrequently and are relieved by administering a thiazide diuretic; if edema progresses or signs of pulmonary congestion appear, discontinue drug. A rise in BUN has been observed. Other rare reactions include breast enlargement, lactation, impotence, decreased libido, skin rash, mild arthralgia, myalgia, paresthesias, Bell's palsy, parkinsonism, psychic disturbances including nightmares, reversible mild psychoses or depression. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Note: Dosage should be limited initially to 500 mg daily when following previous antihypertensive agents other than thiazides. Maximal recommended daily dose is 3.0 g. Patients with impaired renal function may respond to smaller doses than patients with normal kidney function. Syncope in older patients has been related to increased sensitivity in those with advanced arteriosclerotic vascular disease; this may be avoided by lower doses. Tolerance occasionally seen either early or late, but more likely between second and third month after initiation of therapy; increased dosage or combined therapy with a thiazide frequently restores effective control.

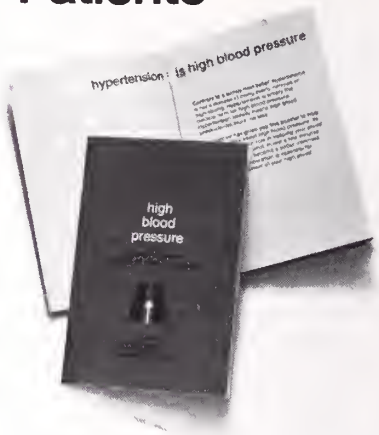
How Supplied: Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., INC., West Point, Pa. 19486

addendum

MSD
MERCK SHARP & DOHME

"Required Reading" For Your Hypertensive Patients



Because of the importance of patient motivation, Merck Sharp & Dohme offers "High Blood Pressure," a concise, pocket-sized booklet that defines the patient's own role in the management of hypertension. This booklet is available for you to give to your patients. It is designed to reinforce your explanation of hypertension and it emphasizes the importance of patient understanding in adhering to the regimen you prescribe.

Please ask your Merck Sharp & Dohme Professional Representative or write Professional Service Department, West Point, Pa. 19486 for a supply of this booklet.

achieve an insight into how our system works. The foreign medical graduate could be prepared to accommodate to the differences he will experience in our country. This would eliminate the embarrassment brought about by ignorance and faulty behavior. If professional prejudices which generally arise out of misunderstanding could be eliminated, then other working relationships advantageous to everyone could more easily be satisfactorily accomplished.

Language Important

To acquire proficiency in language is a problem of greater or lesser degree with most foreign graduates. To speak and understand English perfectly may not be enough. Since medical education involves a great deal of physician-patient contact, all parties involved must be able to understand each other. Therefore, a colloquial language is necessary and must be a part of each orientation program. This may vary a great deal between large urban centers and smaller ones, between Northern areas and those in the South, and between regions highly industrialized and those more quietly agricultural. The Board of Commissioners of the Commission on Foreign Medical Graduates considers orientation a top-priority item and has given approval to obtain funds for the organization and implementation of multiple pilot projects to provide the necessary cultural, linguistic, and medical orientation.

Placement of foreign medical graduates in good educational settings tailored to specific needs is much more difficult because of factors which brought about mass migration of physicians to this country. Solutions of other problems which face the foreign medical graduate are directly related to, and the result of, the "special" national and global problems. Some of us are familiar with the "push-pull" cliche. "Push" is the term applied to many foreign medical graduates, particularly from underdeveloped countries, who are unable to find adequate professional opportunity and satisfaction in their own countries and who are eager to migrate to this country. The "pull" interpretation is related to those factors brought about by the presumed shortage of physicians in this country. The word "presumed" is used since the presence of a shortage may vary in regard to one's interpretation of the current problem. Whether or not there is an actual shortage of physicians, we know that the major "pull" factors are a plethora of internships and residencies far in excess of the yearly output of physicians from American medical schools, and the need for physician manpower by

(Continued)

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state mental institutions; and the need for physicians in the medically understaffed areas. One could postulate that the major factor giving rise to the "push-pull" phenomenon is the lack of health planning in the United States and abroad. Our present situation could conceivably continue until the United States takes the leadership in making decisions regarding policy.

Two Questions

If we are going to formulate a national policy, we will need to give a great deal of thought to these two questions:

1. Is the United States willing to make the necessary expenditures to produce enough physicians to meet its own needs?

2. If there is to be a limit on expenditures for physician manpower needs in the United States, will it be our procedure to import enough physicians to make up the difference between what we are willing to finance and what we actually need?

If we are to finance all of our needs from our own country, then legislative action will be needed to decrease the exodus of physicians from other countries and concomitantly we must resolve the problems associated with Americans studying medicine abroad. We could continue to train foreign physicians in this country, but there would need to be stringent requirements for their return. On the other hand, if we are not going to finance or train our own then we must devise a mechanism wherein immigrants are placed in training situations tailored to their needs so that they may become equally qualified and meet the same standards required of American graduates. This course of action would no doubt enhance the accusation that we are encouraging the "brain drain" from underdeveloped nations. One might again be reminded of the furor created by statistics which were compiled in 1971 when 950 South Korean physicians became permanent immigrants in this country. The magnitude of this figure is better understood when one realizes that there are only 11,000 physicians in all of South Korea.

It is estimated that at present there are somewhere between 8,000 to 10,000 physicians in the United States who are unable to enter the health care field. These individuals are either permanent immigrants or recent American citizens. There is need for a program to provide remedial instruction to qualify them for licensure, or as an alternative, place them in medical situations not requiring a license to practice.

Is Training Correct?

Lack of a health policy in underdeveloped nations contributes substantially to one of the problems about which we are severely criticized. We are constantly accused of training physicians in skills for which they have no use when they return to their native lands. It would seem that we could become very helpful if the nation from which the medical graduate comes would specify what its needs are. I do not believe that such information has ever been made available to date. Since the Commission on Foreign Medical Graduates has assumed sponsorship of Exchange Visitor Foreign Medical Graduates, statistics have been compiled. We now know the number who come here as interns, residents, and fellows. We also know the various specialty training programs in which they are engaged and the countries from which they come. Training programs could surely now be more easily constructed to meet the specific needs of their countries. Special problems relative to appropriate training arise out of the fact that some countries probably do not know their needs and some may care little whether their physicians migrate to our shores.

We need to begin to face the problems which may be created because of the ease of coming to this country as a permanent immigrant. What will happen if the current migration of foreign medical graduates continues or increases? Will a state of confrontation develop between our own students and those of foreign countries? We could expect to experience the same reaction as that which arose out of the excessive immigration of engineers and mathematicians. Should the "1972 Manpower Report of the President to Congress" by the Department of Labor be correct, then the physician shortage should end by 1976. We could find ourselves in conflict because of excessive immigration of health manpower at that early date. HEW is cognizant of this problem and is presently developing projections of health manpower needs for this decade and also into the 1980s. The difficulty previously experienced has been the lack of accurate data as to numbers, training, and the role of the foreign medical graduate in the present health care system. This data base which is now being developed will rely heavily on statistics obtained from the private sector which has lacked coordination up to the present time. While all of these projects are being further developed, the foreign medical graduate will undoubtedly continue to play a very important role in our health care operation.

All that needs to be said about the plight of the foreign medical graduate would require a seminar of several days duration. Since more accurate data is being developed, a seminar should be considered for the very near future.

My thesis can be summarized by simply saying that the foreign medical graduate has problems of psychological depth resulting from just being an immigrant and that, perhaps more important, the solutions to all of his problems are not possible until major issues of health planning both in the United States and abroad are resolved.

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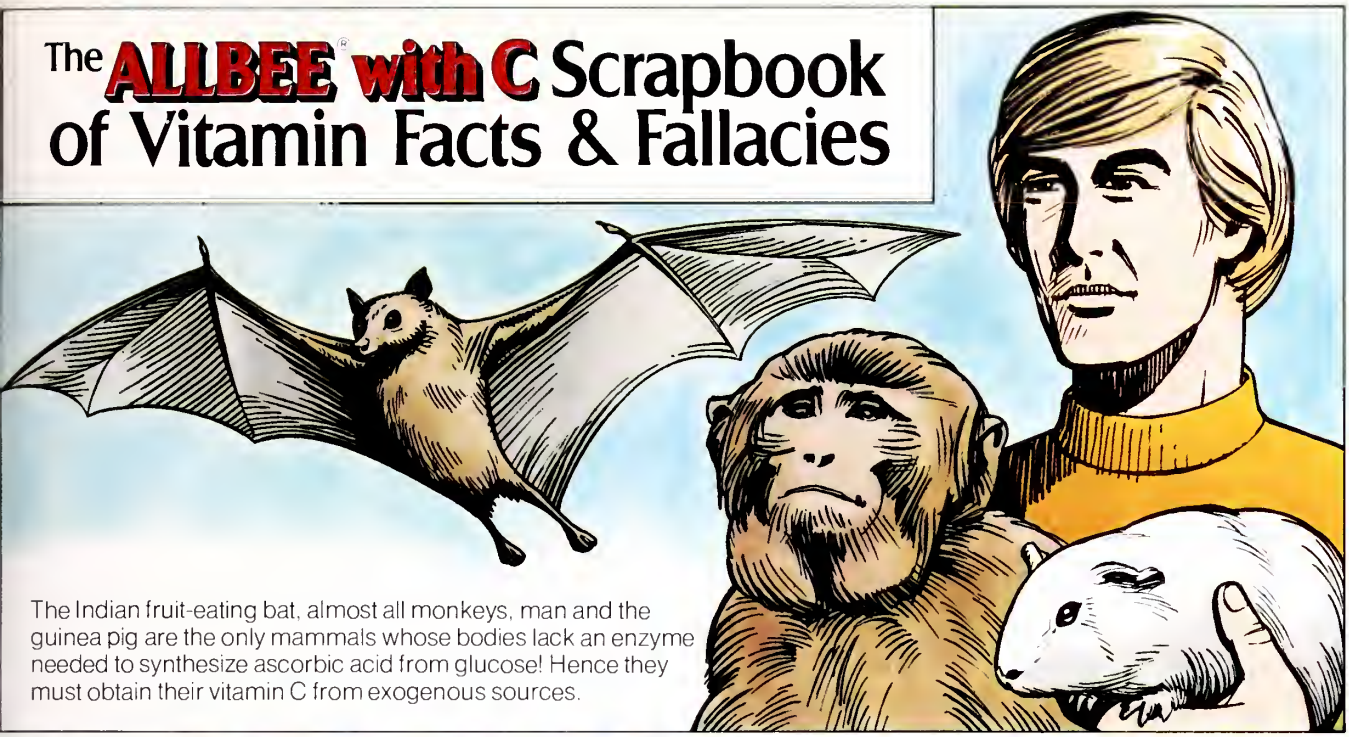
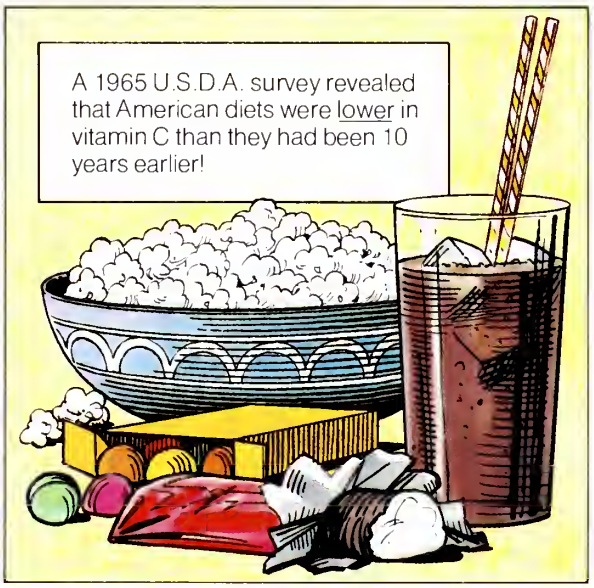


The Indian fruit-eating bat, almost all monkeys, man and the guinea pig are the only mammals whose bodies lack an enzyme needed to synthesize ascorbic acid from glucose! Hence they must obtain their vitamin C from exogenous sources.

De Joinville writing about a 13th century crusade reported that barber surgeons had to "cut away the dead flesh from the gums to enable people to masticate their food." The disease he described was probably scurvy.



The outer leaves of cabbage and brussels sprouts contain more vitamin C than the heads. Yet, ironically, these are often trimmed away by the grocer to improve appearance and enhance sales appeal! Many housewives trim them even more before cooking!

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Brief summary. Adverse Reactions: Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Contraindications: Glaucoma; renal or hepatic disease; obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); or hypersensitivity to any of the ingredients.

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1. Hospitals with sizeable numbers of FMGs should be encouraged to establish an "orientation course" for interns.

2. Each FMG should be taken "under the wing" of an experienced U.S. physician in a "big brother" system until he becomes familiar with the way medicine is practiced in the U.S.

3. There should be intensive training in basic emergencies the first month of the FMGs training.

4. Hospitals should send literature lists on medical life in the U.S. to FMGs prior to their arrival.

5. Programs should be developed to help the FMG, spouse and family overcome the inevitable "cultural shock" upon exposure to the American way of life.

It was felt that the best way to implement these recommendations would be via teaching hospitals as they receive the FMGs newly arrived from their home countries.

The Genesee County Medical Society was chosen to carry out the pilot project because of its size, neither too small nor too large. Flint has three teaching hospitals, which have 79 FMG house staff members.

St. Joseph Hospital in Flint has a year-long program of English classes which meet twice weekly in the evening. St. Joseph willingly opened these classes to FMGs from the other two hospitals, McLaren and Hurley. St. Joseph interns and residents are required to attend these classes until they have proven themselves capable of speaking and understanding the language. Proficiency in English is important as the average house staff member interacts daily with about 40 people — other physicians, secondary health staff, patients, their families and hospital personnel.

Favorable Response

The review by FMGs of these four hours of weekly English lessons has been favorable. Doctor H. C. Lee, a Korean intern, voiced the only complaint, "The only problem is that we are sometimes interrupted in class to answer calls." Doctor S. A. Khodaei, an intern from Iran, confessed, "I was in near panic my first day at St. Joseph because everyone seemed to speak so fast. I would just nod my head and say, 'yes, yes,' when I really didn't know what was going on. I am much more confident now, especially after having taken four months of language lessons."

Perceptions of FMGs

Participants in one workshop unanimously believed that FMGs were mistreated and perceived by their U.S. colleagues and the public to be inferior while participants in the other said they did not feel any hint of discrimination and felt that once FMGs had finished their training and passed their state licensure examinations, they were treated the same as any other U.S. physician, as it should be.

Doctor Hodari, who attended medical school in Argentina, said:

"There is a basis for FMGs to feel inferior because they are, during their postgraduate training the first two to three years. Most medical schools of developing countries, in Asia and South America, are just not up to the standard of medical schools in the United States. Their training in basic medicine is way below; many of them only know how to treat some diseases when they first arrive and most have never done any surgery before.

"Initially, FMGs are inferior because of their lack of knowledge of medicine and also because they are not willing to take on responsibility, in comparison with their American peers.

Doctor Hodari goes on to say that culture plays quite an important role too. "Whereas an American resident will correct me or draw my attention if I have not done something right, a resident, say, from Korea, will not say anything because in his culture he is taught never to correct his teacher or superior.

Variations in Training

John W. Moses, MD, director of medical education at Mt. Carmel Mercy Hospital, Detroit, is essentially of the same opinion. Doctor Moses said:

"There is no question but that there is a difference in training. Between 12 to 18 per cent of FMGs in our training program are equivalent to their U.S. peers. Whether they will catch up or not depends on their level of education, their level of intelligence and their interest. Some FMGs do not have as much training of the intellect as their U.S. counterparts."

In response to the question of how U.S. MD's view FMGs, Doctor Moses replied, "The major factor is a lack of both sides understanding the social mores and background of each other. A great deal of this is due to the inability to communicate — some of this may be due to differences in training.

"The secondary item is that the house staff of today is more demanding in monetary attitude. This applies for both groups, U.S. and FMGs, but people resent it more in FMGs. Also, the secondary health staff is treated differently by FMGs — again because of cultural differences. The U.S. MD observes this and the result is a backlash attitude of U.S. MD's toward FMGs then.

"FMGs may feel they are second class citizens because they, for the most part, have not tried to

(Continued)

assimilate culturally. They tend to mix in their own enclave.

The executive officers of several county medical societies with a large number of FMG members do not believe that FMGs are treated differently within the membership body. Jack Kantner, executive secretary of the Ingham County Medical Society said:

"There is a difference in training but the results after postgraduate training are the same. I look upon FMG members as individuals, no differently than I would U.S. physicians. I do think they are accepted by U.S. MD's as we have several groups of U.S. MD's with FMG associates here in Lansing."

Norman Anderson, executive director of the Genesee County Medical Society, also asserted: "I feel there is no singling out of FMGs any more than of U.S. doctors. Regardless of where he or she comes from, it is the doctor's competence that counts the most."

Participation in Medical Societies

Although two out of three FMGs belong to component and state medical societies, not enough participate actively. To find out the extent of participation, the MSMS asked all component medical societies in Michigan about the number of FMGs holding office or serving on committees for the 1973 year.

There were only 22 respondents. Eighteen of the component medical societies had FMGs holding positions while four did not and of this number, one did not have any FMGs practicing in its county.

There were two presidents, one president-elect, two secretaries, one treasurer, three alternate delegates, nine committee chairmen and 139 FMGs serving on various committees.

From the data shown in Table II, 70 per cent of the 139 committee members were in the metropolitan areas of the state.

More Involvement Needed

While some foreign trained physicians are making a significant contribution to their medical societies, not enough have involved themselves in medical matters to the degree that many have received positions of responsibility in these bodies.

At the Genesee County Medical Society, all incoming members are required to attend an orientation meeting. Mr. Anderson said, "At this orientation meeting, the new members find out about the services that are provided, the advantages of belonging to the county medical society, the state medical society and the AMA; literature is handed out and political activity, such as MD-PAC, is explained."

TABLE II

FMG Officers or Committee Members of County Medical Societies — 1973

County	Pres	Pres-Elect	Sec.	Treas	Alt Del.	Comm Chrmn.	Comm. Mem.
Berrien						2	3
Clinton							1
Delta-Schoolcraft	a	a	a	a	a	a	a
Genesee						1	46
Gogebic	1						
Hillsdale							6
Ingham						2	20
Isabella-Clare	a	a	a	a	a	a	a
Kalamazoo							2
Kent							5
Lenawee	1						
Macomb							1
Manistee			1				
Marquette-Alger	a	a	a	a	a	a	a
Muskegon							5
Northern Michigan							2
Oakland					1	1	36
Oceana	b	b	b	b	b	b	b
Ottawa					1		
Shiawassee		1	1			2	10
St. Clair				1	1	1	1
Washtenaw							1
TOTAL	2	1	2	1	3	9	139

a No FMG holding office
b No practicing FMG in county

At the Washtenaw County Medical Society, Mrs. Louise Moses, the executive secretary, stated, "There have been more FMG members, mostly Iranians, attending meetings the last two years. Committee members are selected from those who attend the general meetings most regularly."

In order to encourage greater participation by FMG members, MSMS will have a special program for them at the Annual Scientific Session, October 9-10 at the Sheraton-Cadillac Hotel, Detroit.

On the morning of the 10th, a practice management workshop will be conducted for interested FMGs and residents. In the afternoon there will be a program outlining the many services offered by the MSMS and short talks about the professional liability situation, PSRO developments, etc. This afternoon program is open to all physicians and it is hoped that the FMG will take advantage of it.

(Continued on Page 582)

Letters

Health Planning Council Hits 'Discriminatory' Fees

Dear Editor:

Doctor Raymond Hockstad's Commentary article, "Discriminatory Payment Practices: A Stringent Barrier to Quality Rural Medicine," *(Michigan Medicine, July, 1974)* expresses a point of view not limited to the Upper Peninsula. A similar complaint was expressed by the Executive Committee of the North Central Michigan Comprehensive Health Planning Council when it passed a resolution in March, 1974, protesting the inequities of the variable fee schedule in the hope that the Michigan Insurance Bureau would work toward the abandonment of this schedule. This Health Planning Council includes the 18 counties across the top of the lower peninsula.

In his letter to the Michigan Insurance Bureau, Council President Richard J. Smith stated "Physician shortage is one of the major health care problems in most of the counties. Physician recruitment is severely hampered by the existence of the variable fee schedule based on geographic location. Many physicians who consider moving to the rural north resent the implication that their services will be worth less money because of geographic location. The fact that historically fees were less does not interest the young practitioner who cannot see that his costs of living will be any less if he chooses to practice in an underserved area, while he does see that the demands on his time may be greater."

Since the Health Planning Council Board must have 51 per cent consumer representatives, the board believed it was important to express a consumer viewpoint in opposition to a practice which prevents access to medical care.

Sincerely yours,
Victor Sztengel
Executive Director
North Central Michigan
Health Planning Council,
Inc. Petoskey

Thank You and Good-bye

To the Readers:

As I leave the staff of Michigan Medicine, I want to thank the authors, the scientific advisors and most of all the physician readers who have made my work here rewarding.

Judith Marr returns to the MSMS staff and will again have primary staff responsibility for *Michigan Medicine* and *Medigram*. All I could ask is that she receive the marvelous cooperation and support afforded to me.

Gratefully,
Jeanne Smith
Managing Editor, *Michigan Medicine*

What makes you think I practice defensive medicine?

Welcome

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

Susan Adelman, MD, 630 Merrick, Detroit 48202
Haresh M. Amin, MD, Wayne County Gen. Hosp., Eloise 48134
Daniel T. Anbe, MD, 2799 W. Grand Blvd., Detroit 48202
Shamshad Anwar, MD, 1026 Superior St., Port Huron 48060
Zeenat Anwar, MD, 1026 Superior St., Port Huron 48060
Horace S. Bell, MD, 600 Lafayette, E., Detroit 48226
Mario S. Benvenuto, MD, 20861 Mack Ave., Grosse Pte. Woods 48230
Wadid F. Berzi, MD, Henry Ford Hosp., Detroit 48202
Charles R. Beyerlein, MD, 100 Michigan Ave., NE, Grand Rapids 49503
A. B. Bhansali, MD, 837 Sylvan Drive, Battle Creek 49017
Renato F. Blanco, MD, 2310 Cass, Detroit 48201
Mario Caniza, MD, 690 Mullett, Detroit 48226
Kong C. Choi, MD, G-5220 W. Pasadena, Flushing 48433
Lawrence R. Crane, MD, 432 E. Hancock, Detroit 48201
Gary M. Eaton, MD, 21415 Civic Center Dr., Southfield 48076
Daniel A. Ekkens, MD, Route 1, Box 178, Bloomingdale 49026
Marcelo B. Espiritu, MD, 754 Lakeland, Grosse Pte. 48230
L. K. Fleetwood, MD, 302 Kensington Ave., Flint 48502
W. James Gallo, MD, 26711 Woodward Ave., Huntington Woods 48070
R. M. Golwala, MD, 767 Fisher Bldg., Detroit 48202
Ellen Gryniewicz, MD, 715 S. University, Ann Arbor 48104
John C. Hall, MD, 7242 Larme, Allen Park 48101
Thomas D. Harris, MD, 1514 Fourth St., Jackson 49203
Lloyd A. Jacobs, MD, 3815 Pelham, Dearborn 48124
Cheng-Chia Ko, MD, 987 E. Larned, Detroit 48234
Cheng-Chong Lee, MD, 19300 Van Dyke, Detroit 48234
Timothy C. Linquist, MD, 199 College St., Battle Creek 49017
Shirley A. McCormick, MD, 302 Kensington Ave., Flint 48502
Loren W. Meengs, MD, 714 Michigan Ave., Holland 49423
Somsak Metriyakool, MD, 1420 St. Antoine, Detroit 48226
Dariouche Mohammadi, MD, W. Fort St.—GMC, Detroit 48209
Aurea C. Montoya, MD, 10113 Pelham, Allen Park 48101
Gerald M. Moredock, MD, 302 Kensington Ave., Flint 48502
John M. O'Lane, MD, St. John Hosp., Detroit 48236
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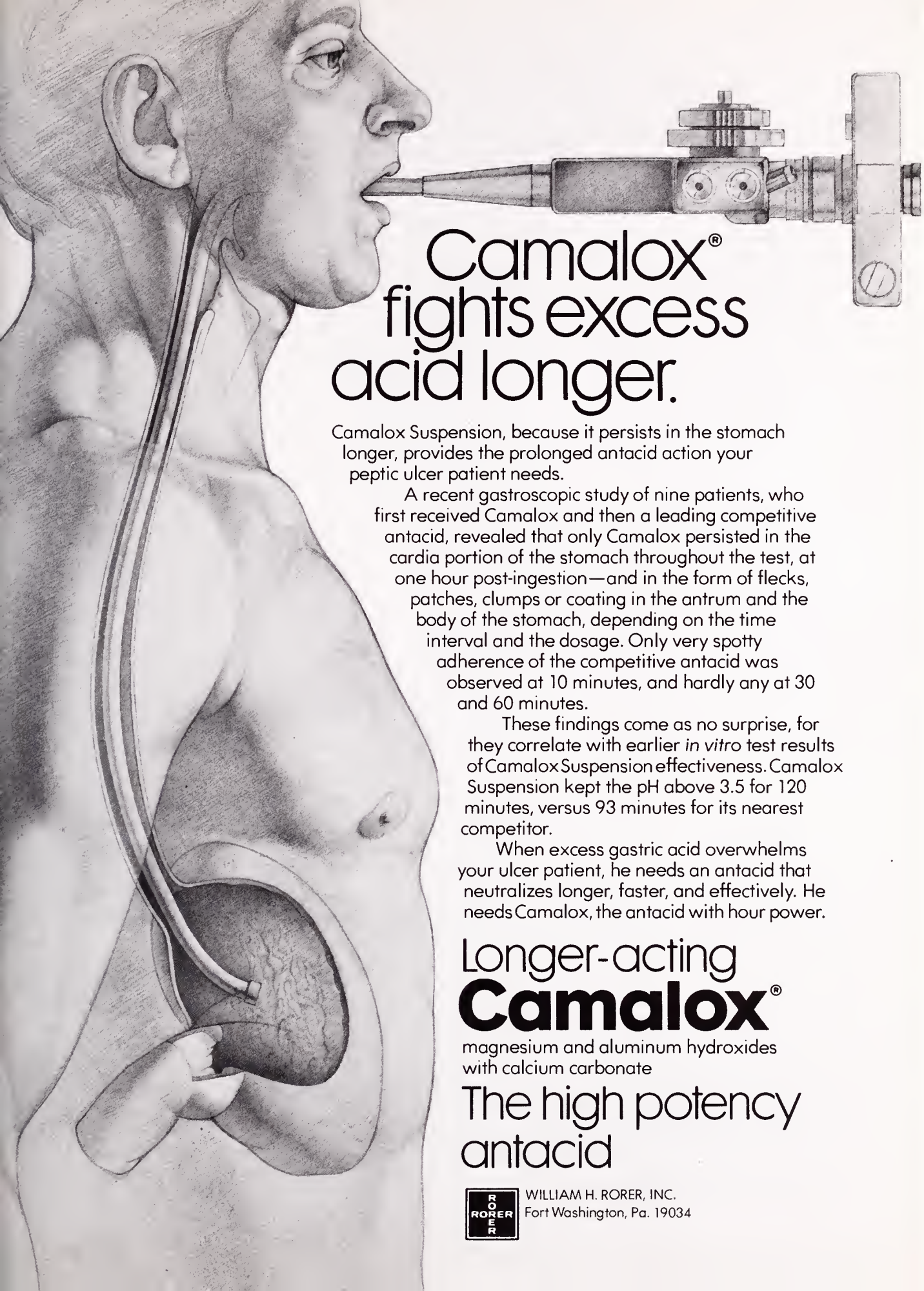

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The Unlicensed FMGs

According to Henry Mason of the American Medical Association, an estimated, and a conservative guess at that, 10,000 FMGs who have not passed their ECFMG examination (which is a prerequisite before an FMG is accepted for postgraduate training in the U.S.) or their state licensure examinations, act as doctors in hospitals. At least 43 states allow unlicensed doctors to practice under various temporary or unrestricted permits in state mental hospitals, public health hospitals, chronic-disease hospitals and TB hospitals. Others have accepted paramedical positions as morticians, scrub technicians, laboratory technicians, etc. Concern about this "medical underground" is rising.

Those Who Remain

Most FMGs come to the U.S. with the intention of returning to their own countries after the completion of their postgraduate education. Increasingly, more and more have elected to remain here. Others return, only to find that they have become strangers in their own countries. There are many reasons for this. According to Doctor Wen, "Back in their home countries, the returned FMGs are not encouraged to rise higher than those who had stayed home. They may find too that they have become over-specialized. Since there seldom is a re-orientation system, it is a cultural shock for the FMG and his family, who had gotten used to the U.S. way of life. The economic factor, living conditions and the degree of political stability at home often induce the FMG to stay on in the U.S."

Many foreign physicians confided they had returned home to stay for as long a period as five years or more before they chose to return here. Very often they found themselves viewed as a threat by their peers and supervisors who had not undergone training abroad. As such, these FMGs found their career advancement blocked. Others returned to their countries only to find they were unable to practice the highly specialized techniques and procedures they had learned, because of lack of sophisticated equipment or other reasons.

Doctor Wen suggested that "The training programs for FMGs here should be geared to the medical needs of their home countries. Most FMGs initially have no idea of the type of training they want. More than just teaching them skills, specialty societies could help them deal with the reality and needs of their home countries.

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In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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MEETINGS

Sept. 16-20—Family Practice Review sponsored by the WSU School of Medicine and the Michigan Academy of Family Physicians, Scott Hall, WSU, contact: Dwight M. Schroeder, MD, Department of Family Medicine, WSU School of Medicine, Detroit 48201.

Sept. 20—Fourth Annual Michigan Cardiovascular Research Forum, sponsored by the Michigan Heart Association at Harper-Webber Hospital, Detroit, contact: Beverly Mercil, MHA, PO Box LV 160, Southfield 48076.

Sept. 20 & 21—Fifth Annual Symposium on "Oral and Perioral Ulcerations: Cause and Control, Emphasis on Herpes Simplex Virus," sponsored by the University of Michigan School of Dentistry and Dental Research Institute, at Kellogg Auditorium, Ann Arbor, contact: Charles B. Cartwright, DDS, U-M School of Dentistry, Ann Arbor, 48104.

Sept. 21 & 22—Postgraduate seminar, "Upper Midwest Review of Gastroenterology," sponsored by the Medical College of Wisconsin's Department of Surgery, Pfister Hotel, Milwaukee, contact: Anne T. Finnegan, Medical College of Wisconsin, Milwaukee 53233.

Sept. 24-26—Postgraduate course on blood coagulation techniques, U-M Medical Center.*

Sept. 25—MSMS Council, MSMS Headquarters, contact: Warren F. Tryloff.

Sept. 27—Annual Meeting of the Michigan Society of Internal Medicine at Hidden Valley, Gaylord, contact: MSIM, PO Box 740, East Lansing 48823.

Sept. 27-29—Michigan Regional Meeting, American College of Physicians, in association with the Michigan Society of Internal Medicine, Otsego Ski Club, Gaylord, contact: Beverly C. Payne, MD, 425 W. Washington St., Ann Arbor 48108.

Oct. 1—Annual surgical symposium, "Surgical Disease of the Pediatric Gastrointestinal Tract, sponsored by the Department of Surgery, Children's Hospital of Michigan, and Wayne State University School of Medicine Department of Surgery, at the hospital, contact: Department of Community Relations, Children's Hospital of Michigan, 3901 Beaubien Blvd., Detroit, Mich. 48201.

Oct. 2—Postgraduate course on "Illness in Children" for social workers, U-M Medical Center, Ann Arbor.*

Oct. 4—Mid-year Meeting, Michigan Hospital Association, Park Place Motor Inn, Traverse City, contact: MHA office, 2213 E. Grand River Ave., Lansing, Mich. 48912.

Oct. 8-10—Postgraduate course in cardiology for internists, U-M Medical Center, Ann Arbor.*

Oct. 9 & 10—1974 Annual MSMS Scientific Meeting, Sheraton-Cadillac Hotel, Detroit, contact: Helen Schulte, MSMS Headquarters.

Oct. 10—Annual MSMS Leadership Conference and MSMS Awards Luncheon, Sheraton-Cadillac Hotel, Detroit, (in conjunction with the Annual Scientific Meeting), contact: Herbert A. Auer, MSMS Headquarters.

Oct. 11 & 12—Annual reunion of the University of Michigan Medical Center Alumni Society, Ann Arbor.*

Oct. 18—Seminar on endocrinology and metabolism honoring Jerome W. Conn, MD, at University Hospital, Ann Arbor, contact: S.S. Fajans, MD, C7204, U-M Hospital, Ann Arbor 48104.

Oct. 18-20—Symposium on radiology of the gastrointestinal system sponsored by the American College of Radiology in Chicago, contact: ACR, 6900 Wisconsin Ave., Chevy Chase, Md. 20015.

Oct. 19—Seminar on "Pediatric Pathology" sponsored by the Michigan Society of Pathologists at the University of Michigan, Ann Arbor, contact: Robert Hendrix, MD, U-M Medical Center.

Oct. 21-25—American College of Physicians postgraduate course on new developments in diagnosis and treatment of disease with radionuclides, co-sponsored by U-M Medical Center, at Towsley Center, Ann Arbor, contact: ACP, 4200 Pine St., Philadelphia 19104.

Oct. 24-25—Fifth Annual Cardiology Symposium sponsored by Borgess Hospital, Kalamazoo, at the hospital, contact: Roberto P. Barcala, MD, director, cardiology services, Borgess Hospital, 1521 Gull Rd., Kalamazoo 49001.

Oct 31-Nov. 2—Course on "Implant Surgery for Joints and Tendons in the Hand," sponsored by the American Society for Surgery of the Hand, at Blodgett Memorial Hospital, Grand Rapids, contact: Alfred B. Swanson, MD, 313 Blodgett Medical Bldg., Grand Rapids, Mich. 49506.

Nov. 6—MSMS Council, MSMS Headquarters, contact: Warren F. Tryloff.

Nov 7 & 8—Cardiovascular symposium on "Diagnosis and Treatment of Congenital Heart Disease," sponsored by Children's Hospital of Michigan and Wayne State University School of Medicine, at the hospital, contact: Eduardo Arciniegas, MD, or Edward Green, MD, WSU School of Medicine.

Nov. 8 & 9—Postgraduate course on advanced burn care, U-M Medical Center, Ann Arbor.*

Nov. 13—Meeting of the Detroit Branch of the American Urological Association, Kellogg Center, MSU Campus, East Lansing, contact: Melvin Hollowell, MD, 10720 W. 7 Mile Rd., Detroit 48221.

Nov. 13—Postgraduate course on "Medicine and Law: Trends and Protections," U-M Medical Center, Ann Arbor.*

Nov. 15—Workshop on "New Health Practitioners—Partners in Patient Care," sponsored by the Institute of Medicine of Chicago, Sheraton-Blackstone Hotel, Chicago, contact: Institute of Medicine, 332 S. Michigan Ave., Chicago, Ill. 60605.

Nov. 15 & 16—Postgraduate anesthesiology conference, U-M Medical Center, Ann Arbor.

Nov. 30-Dec. 4—AMA Clinical Convention, Portland, Ore., contact: Convention Coordinator, AMA, 535 N. Dearborn St., Chicago, Ill. 60610.

Dec. 4—Postgraduate course in cardiology for family physicians, U-M Medical Center, Ann Arbor.*

Dec. 5—PAS and MAP Institute sponsored by the Commission on Professional and Hospital Activities, at Ann Arbor, contact: CHPA, 1968 Green Rd., Ann Arbor, 48105.

Dec. 11—MSMS Council, MSMS Headquarters, contact: Warren F. Tryloff.

Jan. 10 & 11, 1975—Respiratory therapy conference, U-M Medical Center, Ann Arbor.*

Jan. 20-24, 1975—Family practice review, U-M Medical Center, Ann Arbor.*

Feb. 3-7, 1975—American College of Physicians postgraduate course on current concepts in oncology, co-sponsored by U-M Medical Center, at Towsley Center, Ann Arbor, contact: ACP, 4200 Pine St., Philadelphia 19104.

Feb. 18-20, 1975—Postgraduate course in EKG diagnosis, U-M Medical Center, Ann Arbor.*

Feb. 20-22, 1975—Otorhinolaryngology conference, U-M Medical Center, Ann Arbor.*

Feb. 25-28, 1975—Postgraduate course in emergency medicine, U-M Medical Center, Ann Arbor.*

March 5 & 6, 1975—Postgraduate course in advances in pediatrics, U-M Medical Center, Ann Arbor.*

March 10 & 11, 1975—Postgraduate course on "Surgical Complications: Prevention and Management," U-M Medical Center, Ann Arbor.*

March 18-20, 1975—Postgraduate course in morphology of the blood and marrow, U-M Medical Center, Ann Arbor.*

March 31-April 2, 1975—OB-GYN conference, U-M Medical Center, Ann Arbor.*

April 16, 1975—Postgraduate course on orthopedics in family practice, U-M Medical Center, Ann Arbor.*

April 17 & 18, 1975—Course on "Medical Technology/Hematology," U-M Medical Center, Ann Arbor.*

April 21-25, 1975—American College of Physicians postgraduate course on recent progress in clinical endocrinology, co-sponsored by U-M Medical Center, at Towsley Center, Ann Arbor, contact: ACP, 4200 Pine St., Philadelphia 19104.

April 24 & 25, 1975—International conference on andrology, "The Human Semen and Fertility Regulation in the Male," at Wayne State University School of Medicine, contact: E.S.E. Hafez, Ph D, WSU School of Medicine, 550 E. Canfield, Detroit 48201.

May 1 & 2, 1975—Ophthalmology conference, U-M Medical Center, Ann Arbor.*

May 13 & 14, 1975—Postgraduate course in therapeutics, U-M Medical Center, Ann Arbor.*

June 3-6, 1975—Postgraduate course on "Advances in Internal Medicine," U-M Medical Center, Ann Arbor.*

June 23-27, 1975—Northern Michigan summer postgraduate education course for physicians, sponsored by the U-M Medical Center, at Shanty Creek Lodge, Bellaire.*

*Contact Robert K. Richards, Towsley Center, University of Michigan, Ann Arbor 48104.

In Memoriam

J. Frederick Blackhurst, MD
Midland

J. Frederick Blackhurst, MD, 47, of Midland, a specialist in internal medicine, died July 24 while vacationing at his cottage in Roscommon County. Doctor Blackhurst was a graduate of the University of Michigan School of Medicine and had been chief medical advisor for the Midland County Sheriff's Department and a deputy sheriff for 12 years. He was the brother of Robert T. Blackhurst, MD, of Midland.

Wilbur L. Casler, MD
Marquette

Wilbur L. Casler, MD, 87, a family physician and proctologist in Marquette for 51 years, died July 22 in Marquette General Hospital, South. Doctor Casler, a life member of MSMS, was a past president of the Marquette-Alger County Medical Society.

Doctor Casler was a teacher and engineering graduate before entering the University of Michigan Medical School, where he received his MD degree in 1922. He established his practice in Marquette, his home town, the following year.

Alfred Dean, MD
Kingsford

Alfred Dean, MD, of Kingsford, an ophthalmologist in Grand Rapids for 35 years, died June 6 at the age of 91. Doctor Dean, a graduate of Jefferson Medical College of Philadelphia, was a life member of MSMS and of the American Academy of Ophthalmology and Otolaryngology. He served with the army medical corps in World War I.

Lester P. Dodd
Detroit

Lester P. Dodd, 79, prominent Detroit attorney and MSMS general counsel for many years, died July 26 in Southfield. Mr. Dodd was a past president of the Michigan Bar Association and of the Detroit Golf Club.

Harvey T. Fuller, MD
Bellaire

Harvey T. Fuller, MD, 71, of Bellaire and Scottsdale, Ariz., died July 11 in the Munson Medical Center, Traverse City. Doctor Fuller, a graduate of the University of Michigan Medical School, was a family physician in Mt. Morris from 1930 until 1965. He formerly was on the staffs of Hurley, St. Joseph and McLaren Hospitals in Flint.

Elmond J. Gerondale, MD
Southfield

Elmond J. Gerondale, MD, 79, of Southfield, retired Detroit area obstetrician and gynecologist, died July 17 in Hutzel Hospital. A graduate of the Wayne State University School of Medicine, Doctor Gerondale was formerly on the staff of Henry Ford Hospital and had served as secretary of the International Association of Obstetrics and Gynecology. He was a life member of MSMS.

George Kinsley, MD
Pontiac

George Kinsley, MD, 67, a Pontiac physician and surgeon, died July 25 in St. Joseph Mercy Hospital, Pontiac. A medical graduate of Harvard University, Doctor Kinsley was a past president of the Michigan Proctologic Society and a fellow of the American College of Surgeons. He served as an army major in World War II. Doctor Kinsley's hospital staff memberships had included St. Joseph Mercy and Pontiac General and Sinai, Detroit Memorial and Crittenton in Detroit.

Joseph M. McGough, MD
Lathrup Village

Joseph M. McGough, MD, 61, a Lathrup Village family physician, died Aug. 7 in Mt. Carmel Mercy Hospital, where he was a former chief of staff. Doctor McGough was a graduate of the Wayne State University School of Medicine and served as a battle surgeon during World War II.

Charles J. Ozeran, MD
Benton Harbor

Charles J. Ozeran, MD, 62, of Benton Harbor, died July 10 in Borgess Hospital, Kalamazoo. Doctor Ozeran, a graduate of the University of Michigan Medical School, had practiced family medicine in Benton Harbor since 1938 and was on the staff of Mercy Hospital in Benton Harbor and Memorial Hospital in St. Joseph.

John Gilbert Reid, MD
Detroit

John Gilbert Reid, MD, 64, a Detroit area orthopedic surgeon, died Aug. 4 in Harper Hospital. He was on the staffs of Harper, Children's and Jennings Hospitals and the Rehabilitation Institute and was a clinical professor of orthopedic surgery at the Wayne State University School of Medicine.

Doctor Reid, a graduate of the University of Michigan Medical School, was a past president of the Detroit Academy of Orthopaedic Surgeons and an army medical corps veteran of World War II.

(Continued on Page 588)

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Howard Cooper Porsche Audi — Ann Arbor
Pete Alumbaugh Porsche Audi — Flint
Classic Porsche Audi, Inc. — Kalamazoo

Harold B. Rice, MD
Mt. Clemens

Harold B. Rice, MD, 70, of Mt. Clemens, a retired Detroit obstetrician and gynecologist, died July 25 in Martha T. Berry Hospital, Mt. Clemens. Doctor Rice formerly was on the staff of Harper Hospital in Detroit, and he was a fellow of the Michigan Obstetrical and Gynecological Society.

He was a former chairman of the MSMS OB-GYN Section. He was graduated from the Wayne State University School of Medicine.

Alvin H. Seibert, MD
Grosse Pointe Park

Alvin H. Seibert, MD, of Grosse Pointe Park, a practicing physician for 63 years, died July 29 at the age of 90. A graduate of the University of Louisville Medical School in 1905, he came to the Detroit area to practice in 1918 and the next year delivered the first baby born in Grosse Pointe's Cottage Hospital. He became an honorary member of the Cottage staff after his retirement from active practice.

Doctor Seibert was a life member of MSMS and in 1966 received the Exchange Club's highest award, the Book of Golden Deeds.

Ralph N. Tassie, MD
Detroit

Ralph N. Tassie, MD, 83, Detroit family physician, died May 23. A medical graduate of Loyola University, Chicago, Doctor Tassie was a life member of MSMS.

Edward M. Wisniewski, MD
Birmingham

Edward M. Wisniewski, MD, 50, of Birmingham, died July 20 in William Beaumont Hospital, Royal Oak. Doctor Wisniewski, a psychiatrist, received his medical education at Indiana University.

Thomas Brackett Wright, MD
Grand Rapids

Thomas Brackett Wright, MD, 67, a family physician in Grand Rapids, died July 9 in Butterworth Hospital, Grand Rapids. He was a graduate of the University of Michigan Medical School.

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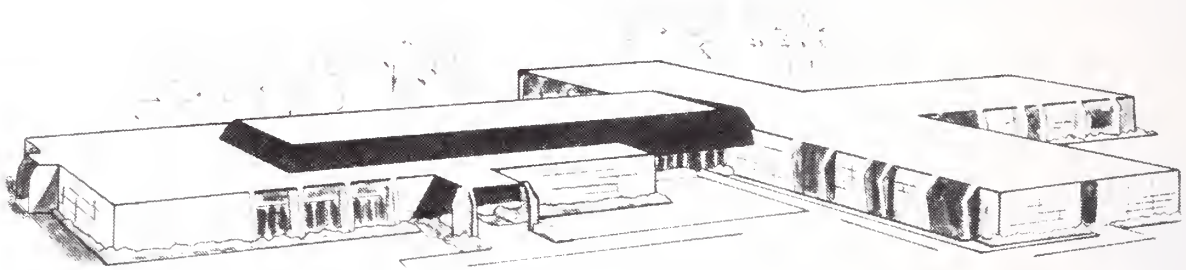

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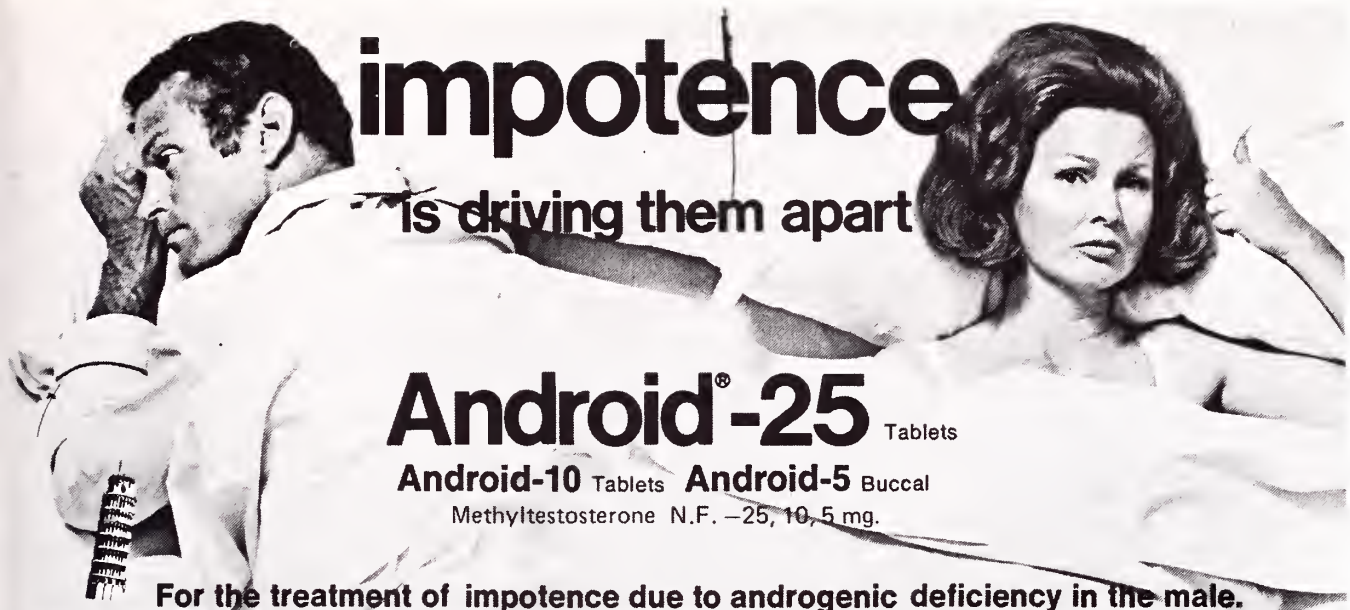

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DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptome when these are secondery to endrogen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpuberal cryptorchidiem with evidence of hypogonedism. Choleatatic hepatitis with jeundice and eltered liver function tests, euch ee increesed BSP retention and rises in SGOT lavels, heve been reported efter Methyltestosterone. These changee appeer fo be related to dosage of the drug. Therefore, in the presence of any changes in liver function festa, drug should ba discontinued. **PRECAUTIONS:** Prolonged dosege of androgen mey resulf in sodium and fluid ratention. This may present e problam, especially in patients with compromised cardiac reserve or renel disease. In treeting meles for eymptoms of climectaric, avoid slimutetion to the point of increasing the nervoue, mentel, and phyelcel ectivities beyond the patient's cardiovaacutar capecity. **CONTRAINDICATIONS:** Contreindicated in persons with known or euspected carcinoma of the prostete and in carcinoma of the mele breaet. Contraindicated in the presence of severe liver demege. **WARNINGS:** If priepism or other aigns of excessive sexuel stimuletion develop, diaconfinue therapy. In the male, prolonged adminietration or excessive dosage mey ceuse inhibition of teaficular function, with resultant oligospermia and decrease in ejeculetory volume. Use cautiously in young boys to avoid premature epiphyseel closure or precocious saxuel development. Hyperseneitivity end gynecomastia may occur rarely. PBI mey be decreased in patients teking androgens. Hypercelcemia may occur, particularly during therapy for metaefatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholastatic jaundice • Oligospermie and decreaaed ejaculatory volume • Hypercalcemia perticulerly in patients with metaefatic breest cercinome. This usually indicates progression of bone metestasee • Sodium and watar retention • Priapism • Virilizetion in female petients • Hypersensitivity end gynecomestia. **DOSAGE AND ADMINISTRATION:** Dosage must ba strictly individuelized, as patients very widely in requirements. Deily requirements era best adminietered in divided doses. The following is suggested ae an average daily dosage guide. In the male: Eunuchoidiem end eunuchism, 10 to 40 mg.; Mela climacteric symptoms end impotence due to endrogen deficiency, 10 to 40 mg.; Postpuberel cryptorchism, 30 mg. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

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PEOPLE

Irving F. Burton, MD, of Detroit,

has been elected president of the Archives of American Art, with headquarters in New York City. Doctor Burton, formerly a vice president of the Archives and president of its Detroit Committee for many years, is a fellow of the American Academy of Pediatrics and the American College of Physicians. He is a trustee and major benefactor of the Detroit Institute of Arts as well as a noted collector.

Harold Chen, MD, of Detroit,

has been promoted to associate professor of pediatrics at the Wayne State University School of Medicine. He is director of the departments of biostatics and cytogenetics at Children's Hospital of Michigan. Other promotions announced by WSU include Alan Neal Wilson, MD, of Detroit, to assistant professor of surgery; Raymond G. Mercier, MD, of Detroit, to assistant professor of psychiatry, and Robert Niccolini, MD, of Grosse Pointe Woods, to assistant professor of psychiatry.

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Beating the Deadline

By Herbert A. Auer, Executive Editor

Whenever discussions get around to runaway baseball games, **George W. Slagle, MD,** Battle Creek, is apt to recall his playing days on the University of Michigan baseball team in 1928 when the Wolverines trounced Purdue 17-0. MSMS Past President Slagle lettered that year on the U-M team that finished with a 17-3 record and won the Big Ten title.

Peter J. Cary, MD, and his wife, **Pamela J. Cary, MD,** both graduates of the University of Queensland Medical School in Australia, recently became associate members of the Genesee County Medical Society. They are both family practice residents.

Thomas A. Dell, MD, JD, FCLM, of Ann Arbor, is the only Michigan physician on the speakers bureau for the American College of Legal Medicine.

The Doctors Band at Grand Rapids has had fun this summer playing at the Woodland Mall and making other appearances. The Kent County Medical Society office reports that the Band includes **Robert D. Burton, MD,** trumpet; **Charles R. Henry, MD,** trombone; **John Stanievich, MD,** clarinet; **Jon Gans, MD,** string bass; **Donald S. Frost, MD,** drums, and **Lee Hart,** (the only non-MD in the group) piano.

Marquette General Hospital has dedicated its medical library as the **Kevin F. O'Brien Medical Library** in memory of Doctor O'Brien, who drowned during the summer in Lake Superior. He was a hematologist and was serving as chief of medicine at Marquette General.

The Kalamazoo Rotary Club recently presented its coveted Red Rose Citation for community service to **William G. Birch, MD.** He received a MSMS Certificate of Commendation noting especially — his leadership to the primary care physician movement in Michigan.

Henry J. Winkler, Sr., MD, was honored at a community event at L'Anse recently for his 50 years of medical service. Legislators, community leaders, other doctors, and special friends were present.

The medical library at the Lockwood-MacDonald Hospital at Petoskey has been dedicated as the **Leonard W. Reus, MD,** Memorial Library. A member of the hospital staff there for 20 years, Doctor Reus was instrumental in organizing the library.

David B. Youel, MD, former director of education for internal medicine at Pontiac General Hospital, recently was appointed educational program coordinator for internal medicine by the Southwestern Michigan Area Health Education Center.

This page will appear each month with news items "on the human side" gathered from correspondence, meetings, conversations and tips we hope you will send in from time to time.

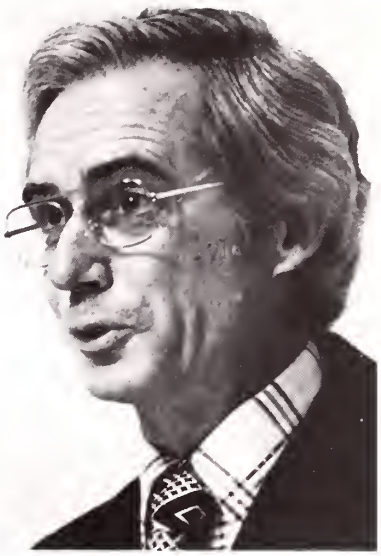
Dr. Dell

Dr. Burton

Dr. Birch

Dr. Slagle

President's Page



Doctor Masters

MSMS Ready To Act Boldly On Malpractice Situation

The Michigan State Medical Society **is prepared** to act boldly to seek solutions to the malpractice situation as soon as the appropriate course is determined.

MSMS has no intention of wasting time and energy on **hopeless battles against windmills.** MSMS shall determine, through the MSMS Committee on Professional Liability efficient ways to seek solutions to the malpractice situation.

* * *

There are at least two distinct parts to the malpractice puzzle as I see them . . .

One part involves litigation. The possible solutions there involve working **with** others. Hopefully our new liaison with the State Bar will have some good results. MSMS is working to support HB 58809 now in the legislature. MSMS can and will cause new legislation in Lansing, and we can seek some solutions in Washington.

The **second major part** of the situation **deals with the availability — and cost — of malpractice insurance.**

The MSMS Committee on Professional Liability, appointed late in 1973, **is working** assiduously to find some remedies to the situation. It has done an amazing job to investigate the avenues which MSMS might take.

The committee sent five recommendations to the MSMS Council, which approved them September 25. The committee feels strongly that MSMS **should give serious** consideration to the sponsored-program approach. The same recommendation — reached after independent research, was made also by the state insurance commission and by the MSMS insurance consultant.

* * *

It is one of the steps that the medical profession can take **itself.** It appears to be perhaps one of the best potential remedies to **immediate needs** while we all work on long-term solutions.

Many facets of the problem can be minimized or corrected by the medical profession, I believe. Doctors **must** do more with continuing medical education. Doctors **must** tighten up peer review. Physicians **can help** establish the professional standards of practice for PSRO. MSMS must conduct workshops and conferences on many related subjects.

Work in these fields **will** have some impact on both the present litigation situation and the questions of insurance availability.

* * *

The MSMS Council, our Committee on Professional Liability, and our staff **all** rate the malpractice situation as our **No. 1 MSMS priority.** Immediate and long-range solutions are possible — **provided we all work together, now.**

Brooker L. Masters, MD

MICHIGAN MEDICINE is the official organ of the Michigan State Medical Society, published under the direction of the Publications Committee Published three times a month, except four times in January, 37 issues, by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and at additional mailing offices Yearly subscription rate, $11.00, single copies, $1.50. Additional postage: Canada, $1 per year; Pan-American Union, $2.50 per year. Foreign, $2.50 per year Printed in USA All communications relative to manuscripts, advertising, news, exchanges, etc., should be addressed to Judith Marr, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823 Phone Area Code 517, 337-1351 1974 Michigan State Medical Society

Both often

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

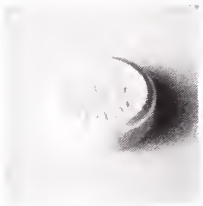
According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

For further information on this subject, the following references are provided:

1. Henry BW, *et al: Dis Nerv Syst 30*:675-679, Oct 1969.
2. Hollister LE, *et al: Arch Gen Psychiatry 24*:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970.



Valium® (diazepam)

2-mg, 5-mg, 10-mg tablets

in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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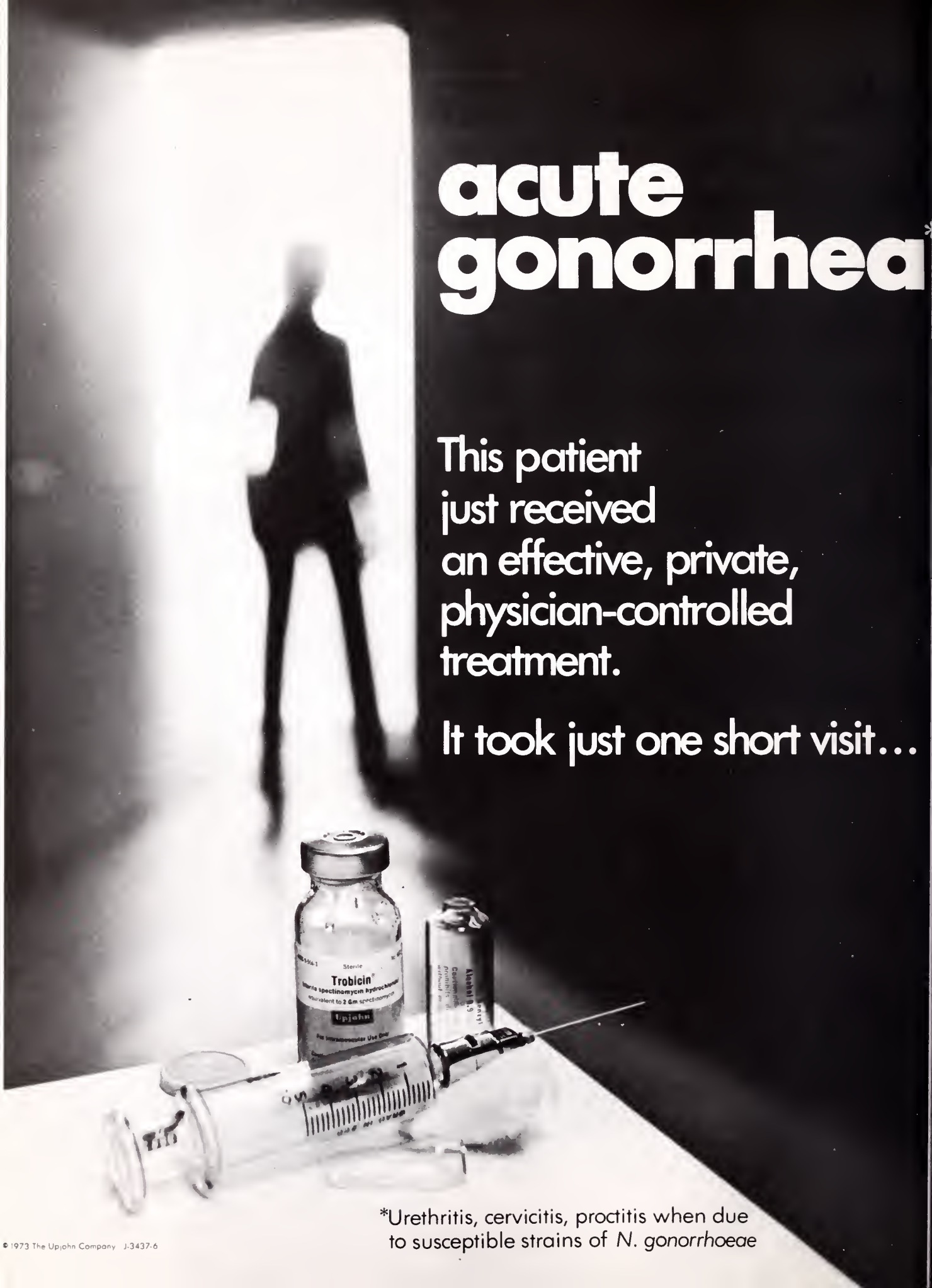

*Urethritis, cervicitis, proctitis when due to susceptible strains of *N. gonorrhoeae*

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Trobicin—The aspect of privacy.
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Trobicin—Indication and dosage.
Spectinomycin is indicated only for use in acute urethritis and proctitis in the male and acute cervicitis and/or proctitis in the female when due to susceptible strains of *N. gonorrhoeae*. The usual dosage for Trobicin in adult males is 2 grams intramuscularly†; 4 grams intramuscularly in females.

Trobicin—Not effective for syphilis.
Trobicin is not effective for any stage of syphilis. Trobicin may mask or delay the symptoms of incubating syphilis. If concurrent syphilis is suspected, follow the patient serologically for at least 3 months. Patients with syphilis should receive adequate specific anti-syphilitic therapy with an appropriate antibiotic.
Trobicin is contraindicated in patients previously found hypersensitive to it.

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2 gm and 4 gm vials

sterile spectinomycin hydrochloride

Sterile Trobicin
Sterile Trobicin (spectinomycin hydrochloride) —For Intramuscular Injection:
2 gm vials containing 5 ml when reconstituted with diluent.
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An aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria gonorrhoeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between spectinomycin and penicillin.

Indications: Acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

Contraindications: Contraindicated in patients previously found hypersensitive to spectinomycin.

Warnings: Not indicated for the treatment of syphilis. Antibiotics used to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Patients should be carefully examined and monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected.
Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions should be observed with atopic individuals.
Clinical effectiveness should be monitored to detect evidence of development of resistance by *N. gonorrhoeae*.

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single- and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25° C and use within 24 hours after reconstitution with diluent.
Male—Inject 5 ml intramuscularly for a 2 gram dose. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.
Female—Inject 10 ml intramuscularly for a 4 gram dose.

How supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of 400 mg spectinomycin per ml (as the hydrochloride). For intramuscular use only.
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† For patients with gonorrheal proctitis and for patients in geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams is preferred.

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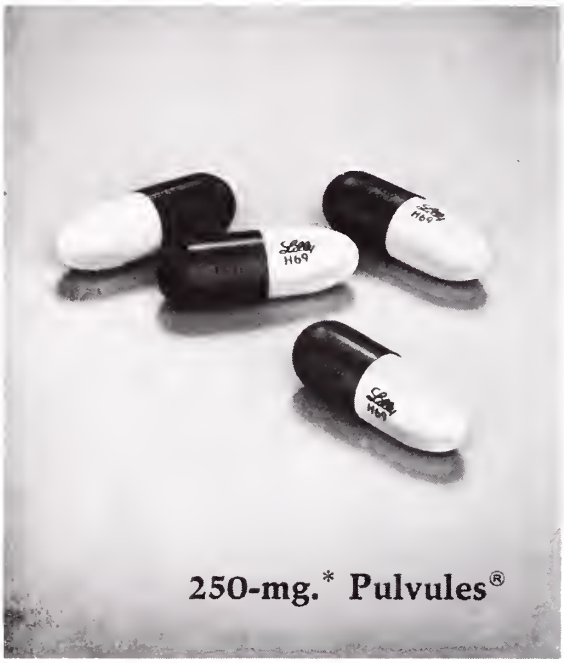

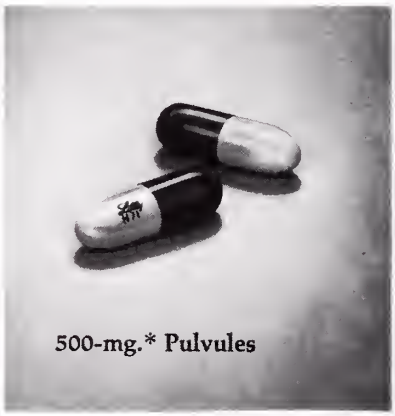

*Equivalent to cephalexin.

Additional information available to the profession on request.

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MSMS Has The Answer To 'Malpractice Problem'

The Michigan State Medical Society has found the logical answer to physicians' current professional liability insurance problems. MSMS is prepared to offer the solution to all its members, if they will unite as a profession.

The answer, arrived at after much study and consultation, is an MSMS-sponsored program, underwritten by a private insurance company. Such a short-term solution will solve the problems of availability and coverage for every MD member.

Negotiations have started between MSMS and major insurance companies to write an MSMS-sponsored program. The advantages would include the following:

—Guaranteed coverage (for a period of years to be negotiated)
—Full disclosure of the financial status of the program
—Physician input in policy decisions
—Cooperation re peer review committees, continuing medical education, etc.
—Lower commissions for insurance agents
—Compilation of accurate information about claims, suits, etc.
—Possibilities of sharing dividends

Problems of availability and cancellation will be whipped when a substantial number of members from all five classes join the sponsored plan, MSMS leaders point out. IT IS EMPHASIZED THAT THE MSMS-SPONSORED PLAN MUST HAVE THE UNIFIED SUPPORT OF THE ENTIRE MEMBERSHIP FOR SUCCESS.

The MSMS Council on Sept. 25 approved seven recommendations including the one to establish an MSMS-sponsored program. The recommendations were made by the MSMS Committee on Professional Liability.

The committee, chaired by John W. Grigg, MD, Bay City, has spent five months studying the problems of professional liability.

Council Approves Recommendations:

Following the committee's recommendations, the Council on September 25:

(1) Authorized MSMS insurance agents to begin negotiations with carriers for an MSMS sponsored program, pending results of a membership survey to determine how many are agreeable to such a program.

(2) Decided to utilize the MSMS insurance consultant (William Cheeseman of Stratton, Cheeseman and Associates, Inc., Lansing) to investigate the possibility of an MSMS self-insured liability program, with a written report and recommendations to be made to the Council soon.

(3) Requested a yearly malpractice survey of MSMS members.

(4) Directed the MSMS Legislative Policy Committee to submit a legislative package of malpractice bills for introduction in the Michigan legislature.

(5) Requested the MSMS Committee on Medical Liability to continue studying the causes of malpractice litigation and to provide information for a comprehensive continuing medical education program to improve areas of deficiency.

(6) Commended the governor, the Insurance Bureau and Insurance Commissioner Daniel Demlow for past assistance and asked the commissioner to continue his outstanding cooperation with the MSMS Committee on Medical Liability.

(7) Agreed MSMS should make a concentrated effort to insure that any national health insurance program have a provision to alleviate the malpractice problem and that the Michigan Delegation to the AMA should convey its recommendations to the AMA House of Delegates.

"The most immediate remedy to solve the problem of availability, not cost," emphasizes Professional Liability Committee Chairman Grigg, "is for an MSMS insurance program with a minimum guaranteed five-year contract of malpractice insurance, and individual premium ratings based on the physician's past claims record. This will assure availability of insurance."

"Such a sponsored malpractice insurance program must have an associated MSMS malpractice peer review committee whose purpose will be to review malpractice cases, identify vulnerable areas, and to arrange continuing medical education to prevent further occurrences."

In addition, he warned MSMS members in Classes I, II, and III must be aware that the incidence of malpractice claims for their classes is accelerating faster than that for Classes IV and V.

"The problems of Classes IV and V today will be theirs tomorrow," he said.

The MSMS Seminar on Professional Liability was well attended Sept. 5 by leaders of MSMS, components, specialty societies, and medical schools. A portion of the audience is shown here.

MDs Must Work Together To Solve Malpractice Issue

"MSMS should develop its own sponsored professional liability insurance program with some major carrier."

That general suggestion was made by three speakers at the MSMS Seminar on Professional Liability in Southfield September 5. And each man reached that recommendation after independent research and study.

John W. Grigg, MD, Bay City, chairman, MSMS Committee on Professional Liability, reported on what the committee has done since its appointment early in 1974. He said the committee is focusing on six areas of work with one of them dealing with the availability and cost of professional liability insurance for all physicians.

Doctor Grigg said "the most immediate remedy to solve the problem of availability is for an MSMS-sponsored insurance program with a minimum guaranteed five-year contract."

State Insurance Commissioner Daniel Demlow said, "I think a sponsored professional liability program is the most viable option because it is a short-range solution to the availability problem — requiring no legislation or governmental action. Carriers are interested if they can be guaranteed broad medical society support and a significant portion of the low-risk business."

Mr. Demlow said he has asked a national authority to draw up legislation for a no-fault concept for medical care and that he will cause such legislation to be introduced yet this fall. He estimated it would take 3 to 5 years to pass in the legislature.

Mr. Demlow warned that if the medical society "wants a governmental solution to your problem, one will be forthcoming . . . however, the biggest cost to you will be increased governmental control over the medical profession."

The MSMS insurance consultant, William Cheeseman, of Lansing, said his research discovered that 30 state medical societies now have sponsored programs for their members. He advocated such an approach for MSMS — now — before Medical Protective and Shelby possibly curtail their Michigan business further.

Any professional liability company, in accepting MSMS sponsorship, Mr. Cheeseman said, would insist on a certain percentage of the total market and a significant percentage of physicians in Classes I, II and III.

In the other presentation at the Seminar, Rhoda Powsner, MD, Ann Arbor, described the efforts of the Washtenaw County Medical Society to work with the county bar association to establish a voluntary arbitration panel system, which will go into effect soon.

In his closing remarks, MSMS President Brooker L. Masters, MD, said, "The MSMS Council, our Committee on Professional Liability, and our staff all rate the malpractice situation as our No. 1 MSMS Priority. Immediate and long-range solutions are possible — provided we all work together now."

Insurance Administrator Cites Advantages of Sponsored Plan

By William Cheeseman, Lansing
MSMS Insurance Administrator

MSMS must act now to develop a contract with a major professional liability company for a MSMS-sponsored group plan for every physician.

We must find a working partner to help MSMS have a successful program.

But don't any of you just sit still and think that anybody is going to come in and do us a favor. We are totally dependent upon the insurance industry.

If we band together, we can confer with the five or six big carriers and assure them of wholehearted, active support of MSMS. Carriers are interested. MSMS can negotiate with them now — before we have a real crisis in Michigan. If we wait, then we will have to take them on their terms, not ours.

The Advantages

Following are the major advantages to MSMS if we negotiate now for a sponsored plan:

—guaranteed coverage
—physician input
—premium control
—free exchange of info
—full financial disclosure
—quick claims reporting
—public education
—physician education
—cost controls
—guaranteed premium

MSMS could decide that guaranteed coverage (for five years for example) could be our No. 1 demand. Thousands of Michigan doctors would have a tremendous shadow over their office blown away if there were no worries about renewals, about cancellations for no reasons, etc. Other plans do contain this desirable feature.

Under a sponsored program, we could encourage quick claim reporting. Most doctors now are neglectful about reporting claims or possible claims. This is understandable because they are worried how a company will use this information in the future, regardless of whether a suit develops. Under a sponsored program, a doctor could call the company if he had the slightest doubt in his mind. We could start doing something immediately to keep it from going to suit.

Another advantage would be public education. The insurance company could work with MSMS to put out literature to help us educate the public on this problem.

MSMS hopefully could try to negotiate a contract with a ceiling on profit. Some of the plans have been negotiated where the company has agreed in writing "our maximum profit will be . . ." We could reduce commissions and that would be a cost savings.

Advantages of a MSMS-sponsored plan were explained by William Cheeseman at recent MSMS Seminar.

MSMS and the company together could strive for cost controls. We could have physicians involved with claims review. Then maybe the claims would start being settled on some better basis.

MSMS could consider some rating flexibility. Doctors are now at the mercy of whatever companies want to do rating-wise. Maybe we should be rating by specialty. Maybe we should be rating by non-standard risk. Not nonrenewing them, but rating them.

Dividends Possible

A sponsored program might result in dividends. Connecticut set up a program and in their second year in the business, they had $120,000 in dividends. Or MSMS might participate in premium investment income.

MSMS could try to negotiate a guaranteed premium. Some programs have that feature. But personally I don't think this is as important as a guaranteed coverage.

The MSMS sponsored program could assure MSMS physician input. We sit and see everybody encroaching on medicine. If you are upset about aspects of continuing education or peer review, then let's propose some alternatives. MSMS could provide the physician input by telling the company how you want this program to be handled.

More and more state medical societies and insurance companies have discovered that a partnership can be developed that is advantageous to both parties. Neither wants government interference.

As I see it, the only way for physicians to win the present struggle is to quickly develop an MSMS-sponsored approach.

(Note: The above is excerpted from the address at the MSMS Seminar on Professional Liability September 5 by William Cheeseman, Lansing, MSMS Insurance Administrator.)

The Insurance Commissioner Looks at Medical Malpractice Insurance Urges MSMS-Sponsored Program

(The following address was made by Mr. Demlow at the MSMS Professional Liability Workshop Sept. 5 in Southfield.)

Delegates, Members of the MSMS staff and fellow guests. I appreciate this opportunity to discuss the problems of medical malpractice insurance as the Insurance Bureau sees it.

The bureau recognizes as its overriding obligation to the doctor the responsibility of maintaining an available market in malpractice insurance. I think everyone in this room would agree that it would be disastrous to the health care delivery system if doctors were absolutely unable to obtain malpractice insurance.

Before discussing the Bureau's role in maintaining an insurance market, it is necessary to discuss why some doctors are having malpractice insurance problems and, equally important, to examine how the insurance companies regard the line of insurance.

Medical malpractice insurance problems are currently being experienced primarily by high risk doctors, those in classes IV and V. The problem basically has two roots: adverse selection and the nature of the risk.

First, the malpractice insurance market in Michigan is dominated by one company, Medical Protective. They write an estimated 65% to 70% of all MD's in Michigan. More importantly, they have concentrated their business in the low risk doctors. One MSMS study indicated that 90% of the class I and II doctors insure with Medical Protective. This means that the majority of the high risk doctors' business is left for other carriers. Because insurance carriers are in the business of making profits by offering coverage to a wide variety of risks, they will not write insurance when they cannot adequately spread the risk. By Medical Protective dominating the low risk classifications, there is no opportunity for other carriers to adequately balance high and low risks.

This market phenomenon is complicated by the nature of the risk. Because an insurance company can be liable for claims incurred in some cases as long as 15 or 20 years ago, it becomes very difficult for an insurance company to estimate when payment will become due and what the levels of payment will be. This is problematic since today's premiums must cover anticipated future losses. Moreover, the frequency and severity of claims experienced particularly by the high risk doctors is so unpredictable that companies are increasingly unwilling to take the risk and gamble with the coverage. One large settlement could totally wipe out a company's malpractice insurance reserves, leaving it in a very vulnerable financial position for a number of years. The nervousness of the companies writing this line of business is highlighted by their willingness to completely forego the premium income guaranteed under a state-sponsored plan when what they consider to be adequate rate increases are not granted. It is also clearly expressed by some companies' complete refusal to accept class IV and V doctors for coverage, regardless of their clean claims history.

No Excessive Profits

From the companies' point of view, medical malpractice is a specialty line involving high, unpredictable risks, extensive administrative costs, and unsure returns for their efforts. It is also a very small volume line of business. The total premium volume in Michigan for 1973 was estimated to be $11 million. This compares with the $900 million collected in auto insurance premiums. Because of the unpredictability of claims and the small premium volume, most companies are simply not interested in writing medical malpractice insurance, no matter what premium rate is approved by a state insurance bureau. If they do offer the coverage, they are very careful to "hedge their bets" by offering coverage primarily to the low risk doctors and dropping any high risk doctors with serious claims history.

COMMISSIONER DEMLOW

The willingness of companies to abandon this specialty market is viewed as being particularly great by insurance experts in light of the industry's reduced earnings for 1974. The latest issue of *Business Week* reports that lines where losses have been severe are being cut drastically. Professional liability coverage was specifically identified as being hard to find. The bureau's

examination of the profit figures for the major Michigan carriers between 1972 and 1973 indicated that there were no excess profits realized. Two of the companies examined experienced net losses after investment income was considered.

The bureau is faced with the responsibility of dealing with a tight and volatile market which is composed of a very limited number of companies. Given this situation, what options are realistically open to the bureau to increase the availability of insurance for the high risk doctor? I would like to run down some of the options most frequently mentioned as solutions to this problem, delineating what the bureau's possible role is. These options will be primarily "insurance" in nature. I will cover some of the possibilities discussed earlier which involve internal system changes, such as binding arbitration.

Five Options Seen

The first option most frequently mentioned is to force admitted malpractice carriers to increase their writing of the high risk business, or similarly require all admitted casualty companies to write medical malpractice business. The commissioner has no legal authority to enforce such a requirement. The Insurance Bureau has regulatory authority in the area of company solvency, rate approval and company licensing. It has no legal authority over a company's decision concerning what line of insurance a company desires to sell within its licensed authority, or authority over which classes companies will actually write.

The Bureau does have some informal influence over company actions, not directly regulated. However, given the companies' hesitancy to write the line, an attempt to informally influence companies could very likely result in the companies withdrawing from the market, or more severely restricting their writing of the line.

This reation by companies to regulatory pressure has been experienced in other states. The probable result of this type of effort to increase availability, would be to, in fact, decrease the availability.

A second major option mentioned is to establish a state-operated fund which provides insurance coverage for the high risk medical doctors. This would be a clear possibility, but would require legislative action and is, therefore, at least one year into the future. If established, the fund would necessarily be a self-sufficient operation. Moreover, to meet the medical profession's needs, there should be no option for the fund to refuse an applicant coverage. While this might sound good, you must realize that the rates which would be needed to sustain the operation would be sky high, probably in the range of those currently charged by Surplus Lines companies, such as Lloyds of London. It would not be cheap, but coverage would be available. I would also like to draw your attention to what I believe is a critical point for you to realize. If you want a governmental solution to your problem, one will be forthcoming. However, with this solution comes costs — the biggest cost to you being increased governmental control over the medical profession.

MSMS's Committee on Professional Liability is making a concerted effort to find solutions to physicians' high malpractice insurance rates. John W. Grigg, MD, Bay City, left, committee chairman, discusses the issue with Daniel Demlow, state insurance commissioner.

A third option might be to set up a private counterpart to a state-operated fund. For example, the high risk classification physicians could establish a mutual company in association with an established company. This option would enable the doctors to obtain more control over their insurance circumstances. Moreover, if claims experience were better than expected, the members could receive premium refunds; however, the reverse would also be true. An association with an established company would offer the technical resources necessary to operate a going concern. I think that if this were financially viable, it would have already been attempted. I believe that the group's composition of high-risk doctors would make the rates prohibitively high, very unstable as to claims experience, virtually unreinsurable, and no venture an established company would be willing to undertake.

A fourth option mentioned is to establish an assigned risk pool, similar to that for auto coverage. Under this scheme, the high risk doctors would be assigned to a company, with any exceptional claims costs being shared by all members of the pool. Since the number of companies writing

Continued: Demlow Urges Sponsored Plan

medical malpractice insurance in Michigan is very limited, a potentially heavy financial burden would fall on a few companies. Given the uncertainty of the market, this unwanted burden could cause further withdrawals from the Michigan market. This would be particularly true if Michigan were the only state to require such a pool.

The Best Option

The last, and I feel the most viable, option I will discuss is that of establishing a state group plan. Since your next speaker, Bill Cheeseman, will be elaborating on this option, I will limit my comments.

I think it is the most viable option because it is a short range solution to the availability problem, requiring no legislative or governmental action. Moreover, carriers are willing to offer malpractice insurance on a group basis, if, and I emphasize the if, they can be guaranteed a significant portion of the low risk business and broad state-wide support. One state-wide plan in a nearby state required an initial enrollment of one-fourth of the practicing physicians. They further require that their insured group be at least 70% class I, II and III MD's. A group plan can clearly benefit the high risk doctors, but if the market continues to tighten and the claims experience worsens, a group plan will also benefit the lower risk doctors practicing in major urban areas.

We have every indication that group coverage can be made available under the right circumstances. However, it will never be available unless a significant majority of the medical profession in Michigan acts in unison. In the past, this sense of unity has not been in evidence.

As a result, the medical profession has not been able to pursue one of the simplest and most straight-forward options available to meet the malpractice problem squarely. I would like to emphasize that doctors seeking insurance on an individual basis have little or no bargaining power. Today's market is a seller's market, not a buyer's market. If the medical profession joins its resources and seeks a group plan, the opportunity for give and take between the company and the insured group increases dramatically. For example, as a group, doctors are in a better position to obtain claims information, and to influence claims handling procedure.

While this option will probably require a sacrifice in the form of slightly higher premiums for a majority of doctors practicing in the state, it does not carry with it the severe financial risks or legal complications associated with the other options discussed.

The burden of action rests clearly with the medical profession. The Insurance Bureau cannot unilaterally solve your problem under existing statutes. If the bureau does step in with a predominantly governmental solution, it will require new legislation and will have its costs. Other less involved solutions are available. The bureau will be more than happy to facilitate the implementation of the solution the state medical profession decides upon. We await your decision.

MSMS Works to Support SB 809 in Legislature

MSMS is hoping for passage this year of a bill which offers promise of alleviating some of the malpractice problems now facing the state's physicians.

The bill — SB 809 — passed the Michigan Senate on May 21 and is now in the House Judiciary Committee, chaired by Rep. Thomas Guastello.

It would make any agreements, promises, contracts or warranty of cure from medical care or results of services rendered by a member of a state licensed profession void unless in writing.

SB 809 would resolve the problem created when the Michigan Supreme Court ruled a physician was guilty of breach of warranty to cure in the 1971 Guilmet vs. Campbell suit. It places every physician who attempts to reassure patients in a position where charges of warranty may be leveled against him.

Recently, the State Bar's Medicolegal Committee has recognized that medicine is a service, not a product, and probably should not be measured against commercial-type warranty language.

The Guilmet-Campbell ruling affects the physician by making him more likely to voice a guarded prognosis. It creates a dilemma for professional liability insurors who must adjust premium rates for malpractice insurance for the new challenge of breach of warranty findings, and threatens any profession in which professional service takes on coloration of product warranty.

In an MSMS survey recently initiated in Wayne County, 111 of 262 medical malpractice suits filed after the Guilmet-Campbell ruling were accompanied by breach of warranty charges.

The extensive work of the MSMS Council, the MSMS Committee on Professional Liability, and the MSMS Liaison Committee with the State Bar *prior* to August 1 is not reported in this issue of Michigan Medicine because it was reported in detail in the Medigram issue of August 28. This issue of the journal focuses on MSMS efforts *since* August 1 and on many of the activities currently underway.

MSMS Survey Continuing To Seek Litigation Information

The first detailed survey of medical malpractice litigation in Michigan is underway in Wayne County by MSMS Legal Counsel, at MSMS authorization. A preliminary report was made at the May 5 MSMS Council meeting.

At that time, data was released from 266 random cases analyzed by personnel from the firm of Kerr, Wattles and Russell of Detroit. Their analysis revealed much about the diversity and financial impact of malpractice suits in Wayne County.

MSMS, therefore, authorized further study, though work at present is halted as the Wayne County courts undergo a massive transfer of court records to computer banks. A. Stewart Kerr, MSMS Legal Counsel, estimates that the data will be available and therefore easily extracted from the computers by January.

From the 266 cases surveyed so far, however, it was determined that

(1) Approximately seven-tenths of the defendants in the 262 medical malpractice cases were MDs.

(2) Obstetricians/gynecologists led in the few cases where a specialty was named. Anesthesiologists, radiologists and psychiatrists followed, in very low numbers.

(3) Hospitals led by a large amount as defendant institutions, followed by private clinics, professional corporations, laboratories, government institutions and corporations, again in small numbers.

(4) Major Detroit hospitals which appeared in three or more cases were Henry Ford, 20; Wayne County General, 14; Oakwood, 10; Detroit General, 5; Harper Hospital, 5; Hutzel, 3, and Sinai, 3.

(5) In 58 cases, improper diagnostic procedure was claimed; in 23, improper use of pharmaceuticals; in 11, improper anesthesiology procedure. More than half fell under miscellaneous charges.

(6) 111 cases specified injury to the extremities, 44 to the thoracic area; 39 specified death, 22 deformities and 16 corrective surgery required.

(7) The legal firms with the largest numbers of cases for the plaintiffs were those of Lopatin, Miller, Bindes and Freedman; Charfoos and Charfoos; Sommers, Schwartz, Silver, Schwartz, Tyler and Gordon.

(8) Firms with the largest numbers of defendants' cases were those of Kitch and Suhrheinrich; Kerr, Wattles and Russell; and Garan, Lucow, Miller, et al.

(9) The basis for recovery and damages sought breaks down as follows: Negligence and malpractice, 262 cases, with an average claim of $617,576; breach of contract, 111, average $618,438; loss of consortium, 64, for $325,156; assault and battery, 23, for $405,043; breach of warranty, 12, for $489,583; failure to inform, 8, for $807,500; strict liability, 3, for $500,000, and loss of familial association, 2, for $287,000.

In addition, the MSMS researchers reported that a government study in 1970 revealed a 6.9 percent increase in claim files opened that year in Michigan.

U-M Seminar On Law, Medicine

A seminar in "Medicine and Law: Trends and Protections," scheduled Nov. 13 at Towsley Center, University of Michigan Medical Center, is offered for all Michigan physicians.

The seminar, jointly sponsored by the Wayne State University and University of Michigan Law Schools and the State Bar of Michigan, will include sessions on the current professional liability situation, new developments in the law of medical malpractice, anatomy of a claim and suit, professional liability insurance, preparation of physician for litigation, alternatives to litigation office management and physicians' estate planning.

Among the participants will be A. Stewart Kerr, Detroit, MSMS Legal Counsel; John W. Grigg, MD, Bay City, chairman, MSMS Committee on Professional Liability and Rhoda Powsner, MD, Ann Arbor, member, MSMS Committee on Professional Liability.

Hospital Rates Climb in State

The Insurance Services Office, the rating bureau for insurance companies, has filed with the Michigan department of Insurance new rating factors that cover the hospital professional liability insurance rates. Based upon $100,000/$300,000 limits of liability the old rates were computed to be $170.13 per bed. Effective September 11, 1974, the new rates are expected to be $210.00 per bed for the same limits.

The increased factor will mean an increase to the Michigan hospital industry of approximately two million dollars annually. (Quoted from Michigan Hospital Association Monday Report)

The Michigan State Medical Society will soon make it possible for every member to have adequate professional liability insurance, regardless of his past experience or class rating. Now it is up to MSMS members to unify as a profession and support development of an MSMS-sponsored insurance program. Voice your approval when you are polled soon.

Answers to Malpractice Questions Doctors Frequently Ask

What commitment does MSMS have to work on the malpractice situation?

About a year ago, MSMS officers agreed with recommendations of the staff that several specific priorities be selected for major attack in 1974. MSMS committees, officers, and others reached some tentative decisions in the fall, putting malpractice as number one. A postal card survey was sent to every member who was asked to rank a list of major issues. The return was very good.

Members indicated they felt No. 1 should be, "To seek relief from malpractice problems."

MSMS staff then suggested five specific activities to move toward that goal. The MSMS Council on December, 1973 approved a plan of work. The major responsibility was assigned to the new, expanded MSMS Committee on Professional Liability.

The MSMS Council on Aug. 2 received a detailed "Progress Report on 1974 MSMS Objectives." The Council adopted a motion to "express its congratulations to the MSMS committees and staff members for their work, and urge them to continue their efforts to seek solutions to the problems outlined in these objectives, particularly professional liability." The Council also requested that the progress report be reprinted in *Michigan Medicine.*

That progress report does appear as the special 12-page printed, yellow *Medigram,* that was mailed to all members on Aug. 27. (Extra copies are available at this meeting.)

The report outlined work prior to Aug. 1 under four general headings (1) Efforts of the MSMS Committee on Professional Liability, (2) Liaison with the State Bar, (3) Legislation, and (4) Communications.

The MSMS Committee sponsored a "MSMS Seminar on Professional Liability" in Southfield Sept. 5 with 82 physicians participating. The committee sent five recommendations to the MSMS Council for consideration at its September meeting, and met the evening of Sept. 25 to begin to implement the proposals approved by the Council.

MSMS has 14 staff members working now full-time or part-time on the malpractice situation.

* * *

What are the facts about the availability of malpractice insurance?

The Medical Protective Company, which insures about 65 percent of the physicians in Michigan, will no longer provide coverage of physicians in two categories: (1) New doctors in solo practice in Wayne, Oakland, Macomb and Genesee counties, and (2) physicians in the high risk Classes IV and V who have claims history that resulted in settlement payments and seek to join professional corporations or partnerships already insured by the company.

Percentage of Michigan Physicians In each Classification for Professional Liability Coverage

	% of Physicians
Class 1	38.3%
Class 2	20.9%
Class 3	5.0%
Class 4	17.6%
Class 5	18.2%

The Shelby Insurance Company, the second largest underwriter in Michigan, has curtailed new business in a number of situations. The company now will not write coverage for (1) new emergency room physicians, (2) physicians who have been dropped or not renewed by another carrier, and (3) Class IV and V physicians who had suits filed against them within the last three years.

MSMS has learned that St. Paul, Aetna and other carriers are in the process of not renewing many of their insureds in Classes IV and V, and with rare exceptions, are accepting no new business.

State Insurance Commissioner Demlow declares that coverage is available for every doctor but in some cases the premiums may be very high.

* * *

How much are Michigan doctors paying now for malpractice insurance?

According to surveys made by the MSMS staff and according to information obtained from the insurance firms, Michigan physicians in Class I are paying about $500, while doctors in Class V generally have annual premiums of $3,000-$4,000.

Figures then go upward for physicians who must resort to the surplus line or non-admitted insurance markets, such as Lloyds.

The physicians in Wayne, Oakland, Macomb and Genesee counties are in Area 1, and their premiums for $200,000/$600,000

coverage from Medical Protective Company are as follows:

$574 for Class I
$859 for Class II
$1,846 for Class III
$2,902 for Class IV
$4,345 for Class V

The physicians in all other counties are in Area 2 and their premiums are as follows:

$525 for Class I
$781 for Class II
$1,522 for Class III
$2,372 for Class IV
$3,167 for Class V

In Michigan, 38 percent of the physicians are in Class I, 21 percent in Class II, 5 percent in Class III, 18 percent in Class IV, and 18 percent in Class V.

* * *

How does malpractice situation affect the public?

Governor Milliken and other state officials are concerned especially about two of the ramifications of the malpractice situation that directly affect the general public.

It is obvious and understandable that physicians do pass on to the patient and third-party carriers the substantial increases that doctors must pay in malpractice insurance premiums. Thus, the cost of medical care is increased immediately or as higher profiles are recognized by third-party payors. MSMS has heard of cases where an individual general surgeon, for example, is now paying $16,000 for his malpractice coverage.

There likewise is growing recognition that the present difficulty in obtaining malpractice insurance is keeping new physicians from practice in Michigan. Michigan does have shortages of doctors in some geographic areas and in some of the medical specialities — and that situation will worsen if insurance is not readily available at rates comparable to other states.

In the past, most older physicians have gradually limited their practices but still continued to serve some of their patients. There are some indications that the situation is changing because older physicians now are more apt to stop practice completely rather than continue to pay their high malpractice premiums.

Recently, the four top officers of MSMS conferred with Governor Milliken on subjects of common concern. The malpractice situation was discussed in some detail. Governor Milliken has requested the state insurance commissioner to give major attention to find possible solutions to the situation. State Insurance Commissioner Daniel Demlow has conferred with the MSMS Committee on Professional Liability and some matters are being pursued jointly.

Interest was high among the 100 physicians who participated Sept. 5 in the MSMS Seminar on Professional Liability at the Northland Inn. MSMS President Masters said the conference was perhaps the most important one sponsored by MSMS in many years.

* * *

How about trying some system of arbitration in malpractice suits?

The MSMS Committee on Professional Liability is on record recognizing that "the system of arbitration is viable, and must remain before the committee as a likely preference."

Arbitration, as you know, generally involved (1) the patient and his advocate, (2) the physician and his advocate, and (3) a third party or parties whose decision may be binding.

There are a variety of approaches to arbitration procedures. The major differences are the degree of compulsion upon the parties and the privilege accorded the proceedings.

The American Arbitration Association has developed a procedure which the MSMS Committee has studied, and feels has substantial merit.

The New York state legislature recently enacted legislation for an arbitration procedure, but there has not been time to test it.

There is no overwhelming court decision yet determining the sanctity of binding arbitration. The Michigan Insurance Commissioner, Daniel J. Demlow, has told the MSMS committee that the application of the present law to medical malpractice is under study.

* * *

Why doesn't MSMS try to work with the State Bar on some solutions?

In addition to the work of the MSMS Committee on Professional Liability, the complex matter is being actively studied by the new "Joint MSMS-State Bar Task Force on Professional Liability." That committee includes John W. Grigg, MD, of Bay City; George D. Stilwill, MD, Lansing and Paul W. Babcock, MD, Detroit, and three attorneys. The

Continued: Is MSMS Working with Bar?

task force has conferred twice in recent months to "explore potential alternatives to the present medical liability litigation procedures." Under study are the weaknesses and strengths of the present operating screening programs used by doctors and lawyers in other states.

The Task Force has its next meeting scheduled in about three weeks. One of the attorney members has told us that he will recommend at that meeting that: a judicial court rule be afforded to require a mandatory screening panel of doctors, attorneys and lay persons to determine whether or not there is any merit to the claim.

That new task force of attorneys and physicians is one of three at work under the new MSMS-State Bar Liaison Committee, which was reactivated late in 1973 through the personal efforts of MSMS President Brooker L. Masters, MD. Doctor Masters called the first meeting of concerned members of the two professions on November 20, 1973. At the next two meetings — December 18, 1973 and January 23, 1974 — it was agreed that there are indeed common concerns that could and should be studied and resolved.

MSMS appointed its five top officers to the liaison committee, and the State Bar named its top leaders. The new parent liaison committee along with nine physicians and nine attorneys who are working on the three special task forces held a long session Feb. 26. The other two task forces are dealing with such issues as the availability of medical records, medical testimony in courts, and other questions about interprofessional relations.

In this same area, MSMS President Masters addressed the State Bar of Michigan Representative Assembly in Detroit March 2 about the malpractice situation, and State Bar President Carl Smith, Jr., spoke to the MSMS House of Delegates in May 1974. Both offered specific suggestions and both expressed hope for new cooperation on common issues.

Malpractice Statistics

MDs lose only about four malpractice cases in court out of an original 100 that may be filed against them, according to an estimate by a leading Michigan defense counsel. Yet, the two or three big cases lost every year cause insurance premiums to rise.

Lawyers say it's a simple matter of arithmetic to determine how much premiums will go up the next year to cover the loss to the insurance company that must pay that rare big settlement.

With no data available and MSMS only now making the first detailed study of malpractice litigation in Michigan, estimates are very rough.

But lawyers guess that there are perhaps 800-1,000 cases pending now against Michigan physicians. Perhaps 50 percent of these are in Wayne County, and the majority are in the tri-county metropolitan area.

Of any 100 cases filed, about 70 to 80 are settled out of court, some for as little as $500-$900.

Of the 20 percent of cases that go into litigation, probably 16 percent are won by the doctor.

Can continuing medical education help solve malpractice problems?

Our committee is actively exploring the best possible ways that MSMS can tie continuing medical education in with ongoing, long-range efforts to relieve the malpractice situation. For example, MSMS through its own research or from information supplied by the malpractice insurance carriers, can find out if some judgements are being awarded because physicians seem to be missing the appropriate diagnosis and treatment of some specific disease or illness. Then MSMS could obtain a panel of good medical experts on that specific subject to travel throughout the state to teach at regional continuing medical education seminars on that topic. That to me seems to be one of the workable elements of a good MSMS "preventive medicine approach." *Michigan Medicine,* our fine MSMS journal, also could carry educational articles on that specific subject in a coordinated educational effort. The Michigan Foundation for Medical Education, which is a creature of MSMS, could seek special funding for such a new project.

MSMS can and should do something in this area. Pennsylvania Medical Society has already started postgraduate educational projects to help reduce physician malpractice risks.

* * *

What did the national Commission on Medical Malpractice ever decide?

The malpractice situation has been studied extensively on a federal level, with no solid suggestions to solve the complex problems.

The Commission on Medical Malpractice of the U.S. Department of Health, Education, and Welfare was established by Executive Directive issued after President Nixon's Health Message on Feb. 18, 1971. The commission officially began its work

in September of 1971 and for 16 months studied all aspects of the medical malpractice problems.

The commission developed its findings and recommendations based on (1) a series of public hearings held in six cities of the nation; (2) ideas from four advisory panels, (3) input from the Interdepartmental Committee on Medical Malpractice, and (4) materials from commission research studies.

The commission published its report to HEW Secretary Elliot L. Richardson on January 16, 1973. The 141-page report has an Appendix of 870 pages. The two reports are three inches thick.

Wendell G. Freeland, an attorney from Pittsburgh, was chairman of the Commission, and in his report he wrote, "We found no simple solutions."

* * *

What are other state medical societies doing?

MSMS staff is compiling now the results of a new survey that was conducted by MSMS in August, asking all other state medical societies about their malpractice problems and activities. Detailed information was sought and has been obtained about other state medical society efforts to sponsor professional liability insurance group programs, and to operate arbitration and screening panels.

Our committee members and MSMS staff members all agree that much can be learned from the experiences of other state medical societies.

Every MSMS member will soon be asked to return a questionnaire to react to the proposed MSMS-sponsored professional liability insurance plan. Watch *Medigram* for further details.

Says Medical Societies See Sponsored Plan as Remedy

A startling picture of unfavorable medical malpractice insurance situations in other states is painted by MSMS Insurance Administrator William Cheeseman, Lansing.

"In New York state, for instance, the underwriter of the sponsored program withdrew after 25 years," says Mr. Cheeseman of Stratton, Cheeseman & Associates, Inc. However, the Argonaut Insurance Company agreed to provide physicians with coverage under a New York State Medical Society-sponsored program.

In order to establish their sponsored program, the New York doctors had to accept a 93.5 percent premium increase. "But no one's complaining; they do have coverage," says Mr. Cheeseman.

Four years ago New Mexico had a liability insurance crisis, despite the fact that New Mexico was considered to have one of the best medical-legal screening panels in the country. New Mexico now is among those states with medical society-sponsored insurance.

In Maryland, the St. Paul Insurance Company asked for a rate increase, which the Insurance Department would not grant. The company pulled out.

"California, of course, has unbelievable problems of all kinds," says Mr. Cheeseman. Soon, the third carrier in recent years will begin handling the Los Angeles County sponsored program.

"This is a terrible situation for the physician's peace of mind," says Mr. Cheeseman.

Citing the Professional Liability Newsletter, Mr. Cheeseman noted that severe claims awards (any amount over $300,000) have climbed in California from three in 1969 to 24 in 1973.

Says Emotional Trauma Suffered By Worried Doctor

Eli P. Bernzweig, J.D., director of the study done by the Commission on Malpractice of the Secretary of Health, Education, and Welfare, has declared:

"Within the past several years the volume of malpractice claims and litigation has been increasing steadily. Professional liability insurance premiums have also increased dramatically during this period. The apparent continuation of these trends is a source of alarm to all health care practitioners and institutions. For the hospital, it is primarily a matter of economics, but for the doctor the spectre of being sued, with all of its attendant emotional trauma, is the harrowing reality which confronts him every day while practicing his chosen profession."

Mr. Bernzweig is now vice-president of Argonaut Insurance Company.

In addition, as of March, 1973, there had been five $1 million suits against physicians in California'a history. But from March, 1973 to March 1974, five more $1 million suits were filed.

Mr. Cheeseman, who advocated an MSMS-sponsored malpractice insurance program Sept. 5 at the MSMS Seminar, says many states see the sponsored-plan approach as the best. Thirty states now have medical society-sponsored insurance programs for professional liability in contrast to two sponsored programs 10 years ago.

(Note: The above is excerpted from the address at the MSMS Seminar on Professional Liability Sept. 5 by William Cheeseman, Lansing, MSMS Insurance Administrator.)

More Questions from MSMS Seminar; MSMS Chairman Writes Replies . . .

Questions were invited from the participants at the MSMS Seminar, but there was insufficient time to answer them all. After the Seminar, MSMS Chairman John W. Grigg, MD, wrote answers to the questions that were routed to him, and the replies to some are below . . .

Statistically speaking, just what is the problem in Michigan, especially in Wayne County?

Bad. There is an alarming increase in the number of malpractice cases filed in the past year. The situation is worse in Wayne County than the rest of the state, but there is an increase statewide. Wayne County is being monitored by MSMS at present for all of the statistical data on malpractice cases. Outstate, the only statistical information is from our MSMS malpractice survey; the latest is now being analyzed.

* * *

A state-society sponsored plan could provide coverage, but shouldn't we attempt to correct the cause of the "disease?"

Of course we must — one recommendation of the Professional Liability Committee is the establishment of a malpractice peer review committee. This Committee will study the reasons why the patient felt compelled to seek legal redress. This Committee will identify the vulnerable areas so MSMS can educate our membership and thus we hope to reduce the number of incidents.

* * *

Can doctors convince the legislature to pass a law to abolish contingency fees and thus reduce malpractice suits and premiums?

Various legislative attacks on the contingency fee system have been attempted, all have failed.

DOCTOR GRIGG

An attack on the contingency fee to lawyers is analogous to the government setting a fixed hourly wage for physicians. There are three times as many lawyers as doctors in Michigan and the vocal opposition is three times as loud in attacking the contingency fee system.

* * *

Why not give physicians the right to countersuit against plaintiffs who lose malpractice suits?

Consider the impact of countersuits. First, it would be an assault on a basic constitutional right. Secondly, if every lawsuit entailed a counter lawsuit, the companies and big businesses with the most money to utilize in lengthy appeals, etc. could circumvent the system of redressing wrongs. This would be in my opinion a gigantic step backward. To countersue one must prove malicious intent on the plaintiff's part. Unfortunately, the one case of a successful physician's countersuit was widely misinterpreted.

* * *

Is there a legislative way whereby a physician can get a signed consent which includes agreement by the patient not to sue the physician?

One cannot "sign away" one's constitutional right. This type of legislative approach is not feasible and is a waste of good time and money.

* * *

Is there a committee (MSMS or otherwise) which can review a claims case for a physician and advise whether or not it has merit?

No, the insurance companies' policy, I believe, is to have the case reviewed by one or two knowledgeable, reliable physicians for their opinion. They also lean heavily on the expertise of their experienced legal counsels.

* * *

Are doctors in the State of Michigan required by law to carry malpractice insurance?

No.

* * *

If not, would it not be feasible to have an uninsured doctors fund to be initiated by the state similar to the former uninsured motorists fund?

Assigned risk pools do not lend themselves to professional liability insurance because of the relatively small number of insureds to share the extra premium surcharges. In automobile insurance they are talking of many thousands to millions. Some insurers, rather than be forced to take certain risks would simply withdraw from the market in Michigan.

* * *

If a doctor is without assets what can happen to him in an

Dean Robert D. Coye, MD, right, of the WSU Medical School, was among those participating in the recent MSMS Seminar on Professional Liability. Dean Coye has conferred with MSMS leaders and staff about the WSU situation.

WSU Medical Faculty Faces Problems Getting Insurance

Alarmed at the effect malpractice insurance problems are having on his faculty, Dean Robert D. Coye, WSU School of Medicine, has written Governor Milliken.

Dean Coye's letter, mailed Aug. 6 to the governor's office, tells of more than 20 faculty members in the process of litigating malpractice suits, of three members of the voluntary faculty who recently have resigned because of their vulnerability to lawsuits, and of three faculty members unable to obtain malpractice insurance.

The university has attempted to provide umbrella insurance for 77 faculty members now underinsured, but requests to five companies to arrange such insurance have met with no success, he says.

"The portents are for a very serious loss of teaching faculty unless we are able quickly to provide our faculty with adequate malpractice insurance coverage," said Dean Coye. "The consequences of loss of faculty at this time while we are attempting to add faculty to meet the demands of a greatly expanded class would of course be disastrous . . . "

The phenomena of rapidly rising insurance rates and less availability of insurance cause "immediate and urgent problems peculiar to the WSU School of Medicine which I must bring to your attention," wrote Dean Coye. "These problems are having a negative impact on the availability of faculty to carry out teaching responsibilities. If they can't get adequate malpractice coverage, they will not be able to teach."

Dean Coye concluded:

"I am deeply aware of our obligation as a state medical school to meet the medical educational goals set for us and am therefore posing the problem to you in the hope that your office, utilizing the resources of the state, may find some means of providing to this faculty the protection they need to carry out their teaching assignments for the state."

adverse settlement? What happens if his insurance company goes under?

It has been frequently stated by some physicians that we might all give up our malpractice insurance and "break the system." Remember, the courts can legally garnishee future earnings. Declaring bankruptcy is an involved process, which I believe would not circumvent the system. We must also remember the Supreme Court has a tendency to liberal decisions and some of their decisions in the past have been somewhat erratic. The Supreme Court could hold that a physician "in anticipation" of a possible malpractice suit has transferred his assets to his wife and therefore could rule that the intent was to circumvent the system and therefore could void this transfer leaving the joint assets open to attack.

I can best say that those who would have their assets in their wife's name, and carry no malpractice insurance remind me of the farmer whose prize bull broke loose and charged a railroad train head-on. The farmer stood back and said, "I sure admire your courage, but I don't agree with your judgment."

* * *

Under the proposed possible MSMS-sponsored malpractice insurance plan would the Group I, II, III physicians be willing to work together with the higher-risk physicians in Group IV or V?

Classes 1, 2 and 3 must realize that is their problem also. It has not directly affected them, but it will.

MSMS Survey Provides First Data On Medical Malpractice Situation

By John Anthony
Donna Allen
MSMS Bureau of Economic Information

Ninety percent of MSMS members who completed a recent MSMS survey of malpractice insurance coverage and litigation termed professional liability problems as 'severe' and even the 'most pressing' for medicine today.

14.8 percent of those respondents indicated they had been named as a co-defendant with a hospital in a suit and 5.7 percent said they had been refused renewal of their liability coverage by their insurance company.

Thus it is clear that nearly all the physicians responding to the survey are worried about the "malpractice problem," though it actually has touched a relatively few of them.

Over 7,700 surveys were mailed by the MSMS Bureau of Economic Information to all active MSMS members. This was at the request of the MSMS Professional Liability Committee, which is studying the scope of the malpractice insurance problem in Michigan.

Nearly 40 percent of the questionnaires mailed were returned, also indicating high interest in the problem. The survey asked for information about the type of practice, limits of liability coverage, insurance carrier, annual premiums, excess liability coverage and claims and suits.

The data collected reveal the following about the MDs who responded:

1. Almost 90% of the physicians feel the malpractice situation is 'severe' or the 'most pressing' problem facing medicine today.
2. 14.8% of the MDs responding indicated having been named as a co-defendant of a suit with a hospital. Area 1 (Wayne, Oakland, Macomb and Genesee counties) is higher than the state-wide percent, with 17.6% responding that they had been involved as co-defendants.
3. When asked if they had ever been refused renewal of their liability insurance, 5.7% responded yes, with 8.0% saying yes in Area 1. Most of those who had been refused were in either Class 4 or Class 5 (these two classes contain most of the surgical specialties). Medical Protective is the insurance company that cancelled the majority of the respondents, with 85 out of 170 naming that company.
4. Ten times as many cases are decided out of court as in court. Of the 71 total reported cases that went to court, physicians won 44 or 72% of them. The in-court settlements averaged over $38,000 and were 3.2 times as high as the average out-of-court settlement of $11,866.

   There were 48 settlements between $10,000 and $35,000; 22 exceeded $35,000; and eight were over $75,000. Class 5 physicians had the highest in-court and out-of-court settlements.
5. Approximately 45.5% pay premiums of $1,000 or less. It is interesting to note that 9.4% of those responding from Area 1 pay more than $5,000 a year for their coverage.
6. Over 60% of those covered by liability insurance also have excess or "umbrella" type liability coverage. Of the 60%, 51.4% had coverage of $1,000,000.
7. Over 95% of the physicians have base coverage of $100,000/$300,000 or higher. The percent of those with $200,000/$600,000 coverage has risen since 1973 when it was 33.8% in a similar survey to 41.1% in 1974.
8. Almost all of those responding (98.4%) are covered by professional liability insurance.
9. The Medical Protective Company insures 63.8% of the physicians in the state who responded. The percent in Area 1 is lower at 57.6%. Shelby Mutual is the second largest insurer with 14.7%. The remainder are insured by Aetna, St. Paul, Lloyd's of London, and various other carriers. 1.6% of the respondents carried no insurance at all, and many of these were involved in direct patient care.

Table 1

	Area 1		Area 2		State	
Specialty Classes	Respondents	Percent	Respondents	Percent	Respondents	Percent
Class 1	552	44.5	550	34.2	1102	38.7
Class 2	92	7.4	171	10.6	263	9.2
Class 3	86	6.9	124	7.7	210	7.4
Class 4	234	18.9	340	21.2	574	20.2
Class 5	277	22.3	422	26.3	699	24.5
Total	1,241	100.0	1,607	100.0	2,848	100.0

Table 2

Carrier	Area 1 Respondents	Area 1 Percent	Area 2 Respondents	Area 2 Percent	State Total	State Percent
Medical Protective	716	57.7	1,102	68.6	1,818	63 8
Shelby Mutual	193	15.6	226	14 1	419	14 7
Aetna	64	5.2	60	3 8	124	4 4
St Paul	70	5.6	57	3.5	127	4 5
Lloyds of London	18	1 4	10	0 6	28	1 0
Other	156	12 6	130	8.1	286	10.0
No Insurance	24	1 9	22	1 3	46	1 6
Total	1,241	100 0	1,607	100.0	2,848	100 0

Table 3

Base Coverage	Area 1 Respondents	Area 1 Percent	Area 2 Respondents	Area 2 Percent	State Total	State Percent
$10,000/$30,000	67	5.4	67	4 1	134	4 7
$100,000/$300,000	509	41 0	769	47 9	1,278	44 9
$200,000/$600,000	519	41.8	652	40 6	1,171	41 1
Other	146	11 8	119	7 4	265	9 3
Total	1,241	100.0	1,607	100.0	2,848	100 0

Table 4

Annual Premium	Area 1 Respondents	Area 1 Percent	Area 2 Respondents	Area 2 Percent	State Total	State Percent
$ 200-500	281	22.6	337	21.0	618	21 7
501-1,000	311	25.1	370	23.0	681	23.9
1,001-1,500	96	7.7	136	8.5	232	8 2
1,501-2,000	51	4.1	107	6.7	158	5.6
2,001-2,500	78	6.3	162	10.1	240	8.4
2,501-3,000	84	6.8	176	11.0	260	9 1
3,001-3,500	95	7.7	147	9.1	242	8.4
3,501-4,000	51	4.1	99	6.2	150	5 3
4,001-4,500	51	4 1	28	1.7	79	2.8
4,501-5,000	26	2.1	13	0.8	39	1.4
5,001 up	117	9.4	32	1.9	149	5 2
Total	1,241	100.0	1,607	100.0	2,848	100 0

Table 5

Excess Liability	Area 1 Respondents	Area 1 Percent	Area 2 Respondents	Area 2 Percent	State Total	State Percent
None	511	41.2	604	37.6	1,115	39.2
$1,000,000	616	49.6	849	52.8	1,465	51.4
$2,000,000	86	6.9	125	7.8	211	7.4
Higher	28	2.3	29	1.8	57	2.0
Total	1,241	100.0	1,607	100.0	2,848	100.0

Table 6

Refused Liabilty Insurance	Area 1 No	Area 1 Yes	Area 1 Percent	Area 2 No	Area 2 Yes	Area 2 Percent	State No	State Yes	State Percent
Class 1	530	22	1.7	540	10	0.6	1,070	32	1.1
Class 2	83	9	0.7	168	3	0 1	251	12	0.4
Class 3	83	3	0.2	120	4	0.2	203	7	0 2
Class 4	206	28	2 2	323	17	1.0	529	45	1.5
Class 5	237	40	3 2	388	34	2 1	625	74	2.5
Total	1,139	102	8.0	1,539	68	4.0	2,678	170	5.7

(Continued)

Table 7

Companies Which Have Refused Insurance	Area 1	Area 2	State
Medical Protective	42	43	85
Shelby Mutual	4	4	8
Aetna	14	3	17
St. Paul	15	2	17
Other	27	16	43
Total	102	68	170

Table 8

	Area 1			Area 2			State		
Co-Defendant Suit With Hospital	No	Yes	Percent	No	Yes	Percent	No	Yes	Percent
Class 1	481	71	5.7	510	40	2.4	991	111	3.8
Class 2	69	23	1.8	149	22	1.3	218	45	1.5
Class 3	82	4	0.3	113	11	0.6	195	15	0.5
Class 4	177	57	4.5	290	50	3.1	467	107	3.7
Class 5	211	66	5.3	337	85	5.2	548	151	5.3
Total	1,020	221	17.6	1,399	208	12.6	2,419	429	14.8

Table 9

Area 1

Malpractice Insurance Situation	Class 1 Percent	Class 2 Percent	Class 3 Percent	Class 4 Percent	Class 5 Percent	Total Percent
Most Pressing Problem	12.6	2.4	1.8	9.9	14.1	41.1
Severe	26.4	3.6	4.2	8.0	7.9	50.4
Not Alarming	4.2	0.8	0.4	0.3	—	6.0
Little Consequence	0.2	—	0.1	—	—	0.4
No Problem	0.8	0.4	0.1	0.4	0.1	2.1
Total	44.2	7.2	6.6	18.6	22.1	100.0

Table 10

Area 2

Malpractice Insurance Situation	Class 1 Percent	Class 2 Percent	Class 3 Percent	Class 4 Percent	Class 5 Percent	Total Percent
Most Pressing Problem	5.4	2.3	1.5	7.1	10.5	26.9
Severe	20.0	6.7	4.7	12.1	14.1	57.9
Not Alarming	7.9	1.4	1.1	1.4	1.3	13.4
Little Consequence	0.2	—	0.1	—	—	0.5
No Problem	0.4	0.1	0.1	0.2	0.2	1.3
Total	33.9	10.5	7.5	20.8	26.1	100.0

Table 11

		Settled				
Malpractice Claim Information	Pending	In Dr.'s Favor	In Court	Average Amount	Out Of Court	Average Amount
Class 1	63	12	1	$ 1,400	32	$14,373
Class 2	25	2	3	43,500	8	3,475
Class 3	12	—	1	3,000	10	9,300
Class 4	60	13	6	10,179	57	9,005
Class 5	126	17	6	75,833	68	14,450
Total	286	44	17	38,292	175	11,866

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MEETINGS

Oct. 11-12–Annual reunion of the University of Michigan Medical Center Alumni Society, Ann Arbor.*

Oct. 18–Seminar on endocrinology and metabolism honoring Jerome W. Conn, MD, at University Hospital, Ann Arbor, contact: S. S. Fajans, MD, C7204 U-M Hospital, Ann Arbor 48104.

Oct. 19–Seminar on pediatric pathology, sponsored by the Michigan Society of Pathologists at the University of Michigan, Ann Arbor, contact: Robert Hendrix, MD, U-M Medical Center.

Oct. 21-25–American College of Physicians postgraduate course on new developments in diagnosis and treatment of disease with radionuclides, cosponsored by U-M Medical Center, at Towsley Center, Ann Arbor, contact: ACP, 4200 Pine St., Philadelphia 19104.

Oct. 24-25–Fifth Annual Cardiology Symposium sponsored by Borgess Hospital, Kalamazoo, at the hospital, contact: Roberto P. Barcala, MD, director, cardiology services, Borgess Hospital, 1521 Gull Road, Kalamazoo 49001.

Oct. 25-26–First reunion of Michigan State University College of Human Medicine Alumni Association, East Lansing, contact: Assistant Dean Thomas S. Gunnings, College of Human Medicine, East Fee Hall, MSU, East Lansing 48823.

Oct. 31-Nov. 2–Second National Congress on Health Manpower, sponsored by the AMA, at The Palmer House, Chicago, contact: The AMA, 535 N. Dearborn, Chicago 60610.

Oct. 31-Nov. 2–Course on "Implant Surgery for Joints and Tendons in the Hand," sponsored by American Society for Surgery of the Hand, at Blodgett Memorial Hospital, Grand Rapids, contact: Alfred B. Swanson, MD, 313 Blodgett Medical Building, Grand Rapids 49506.

Nov. 6–MSMS Council, MSMS Headquarters, contact: Warran F. Tryloff.

Nov. 7-8–Cardiovascular symposium on "Diagnosis and Treatment of Congenital Heart Disease," sponsored by Children's Hospital of Michigan and Wayne State University School of Medicine, at the hospital, contact: Eduardo Arciniegas, MD, or Edward Green, MD, WSU School of Medicine.

Nov. 8-9–Postgraduate course on advanced burn care, U-M Medical Center, Ann Arbor.*

Nov. 11–Annual Wayne County Medical Society Beaumont Lecture; WCMS Headquarters, contact: Else Kolhede, exec. secy, WCMS, 1010 Antietam, Detroit 48207.

Nov. 13–Meeting of the Detroit Branch, American Urological Association, Kellogg Center, MSU Campus, East Lansing, contact: Melvin Hollowell, MD, 10720 W. Seven Mile Road, Detroit 48221.

Nov. 13–Postgraduate course on "Medicine and Law: Trends and Protections," U-M Medical Center, Ann Arbor.*

Nov. 15–Ninth Annual Professional Symposium for Michigan physicians, sponsored by Professional Education Committee of Kent County Heart Unit, Michigan Heart Association, Hospitality Inn, Grand Rapids, contact: Mohammad Riahi, MD, 21 Michigan St. SE, Grand Rapids 49502.

Nov. 15-16–Postgraduate anesthesiology conference, U-M Medical Center, Ann Arbor.*

Nov. 30-Dec. 4–AMA Clinical Convention, Portland, Ore., contact: Convention Coordinator, AMA, 535 N. Dearborn, Chicago 60610.

Dec. 4–Postgraduate course in cardiology for family physicians, U-M Medical Center, Ann Arbor.*

Dec. 5–PAS and MAP Institute, sponsored by Commission on Professional and Hospital Activities, at Ann Arbor, contact: CHPA, 68 Green Road, Ann Arbor 48105.

*Contact Robert K. Richards, Towsley Center, University of Michigan, Ann Arbor 48104.

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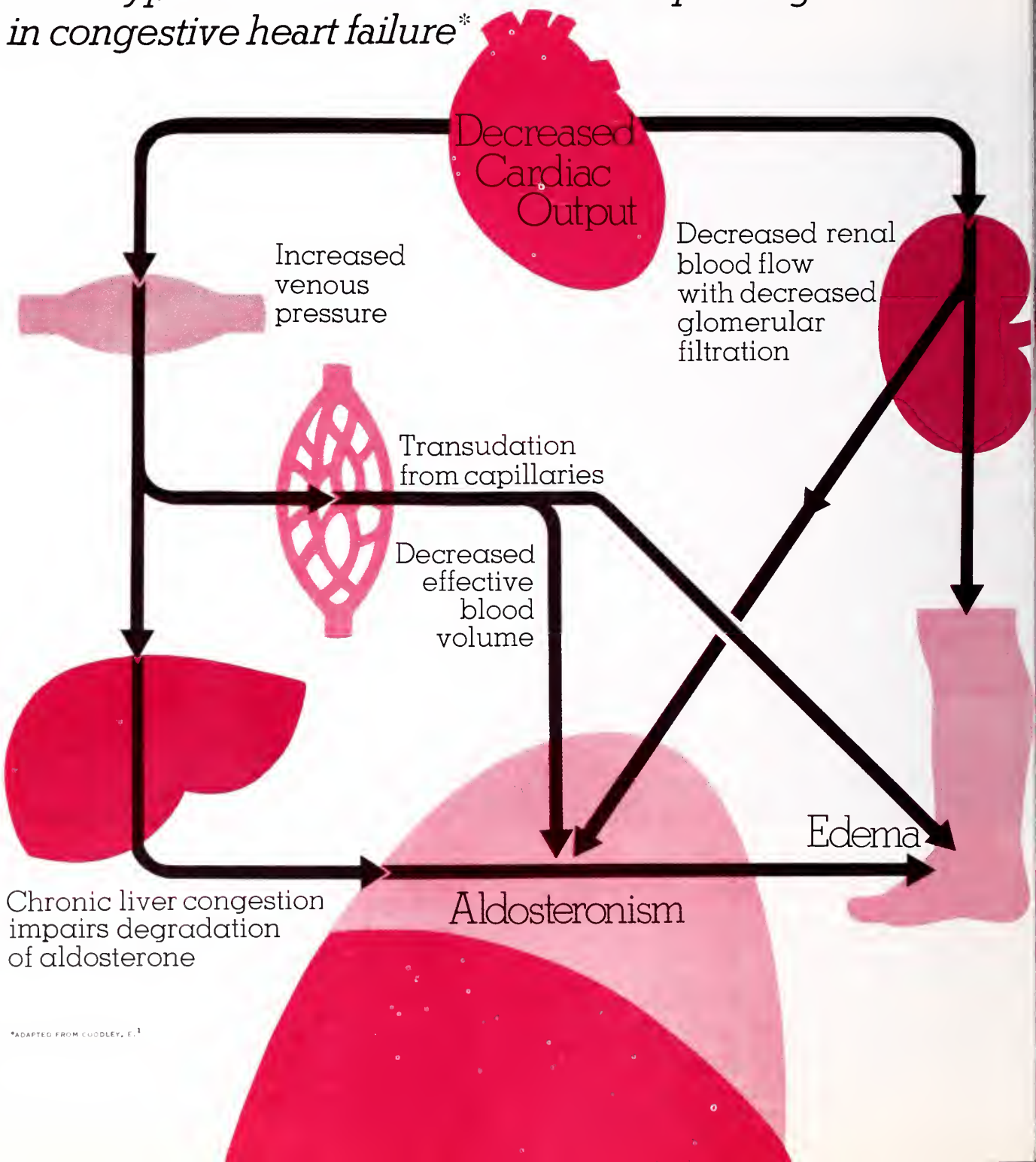
*How hyperaldosteronism leads to and prolongs edema in congestive heart failure**



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- Avoids potassium loss.

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- Can be administered daily as basic therapy with the additional agent (furosemide or ethacrynic acid) given every second or third day.
- Aldactone plus "A.D.D." schedule minimizes potassium deficiency and potentiates effect of "add-on" diuretic.[2]
- Avoids acute volume depletion and aldosterone rebound.[2]

3. As a daily diuretic in combination with a daily dose of a thiazide
- Permits daily additive diuretic effect while maintaining potassium balance.

Indications—Essential hypertension; edema or ascites of congestive heart failure, cirrhosis of the liver and the nephrotic syndrome; idiopathic edema. Some patients with malignant effusions may benefit from Aldactone (spironolactone), particularly when given with a thiazide diuretic.

Contraindications—Acute renal insufficiency, rapidly progressing impairment of renal function, anuria and hyperkalemia.

Warnings—Potassium supplementation may cause hyperkalemia and is not indicated unless a glucocorticoid is also given. Discontinue potassium supplementation if hyperkalemia develops. **Usage of any drug in women of childbearing age requires that the potential benefits of the drug be weighed against its possible hazards to the mother and fetus.**

Precautions—Patients should be checked carefully since electrolyte imbalance may occur. Although usually insignificant, hyperkalemia may be serious when renal impairment exists; deaths have occurred. Hyponatremia, manifested by dryness of the mouth, thirst, lethargy and drowsiness, together with a low serum sodium may be caused or aggravated, especially when Aldactone is combined with other diuretics. Elevation of BUN may occur, especially when pretreatment hyperazotemia exists. Mild acidosis may occur. Reduce the dosage of other antihypertensive drugs, particularly the ganglionic blocking agents, by at least 50 percent when adding Aldactone since it may potentiate their action.

Adverse Reactions—Drowsiness, lethargy, headache, diarrhea and other gastrointestinal symptoms, maculopapular or erythematous cutaneous eruptions, urticaria, mental confusion, drug fever, ataxia, gynecomastia, inability to achieve or maintain erection, mild androgenic effects, including hirsutism, irregular menses and deepening voice. Adverse reactions are infrequent and usually reversible.

Dosage and Administration—For **essential hypertension** in **adults** the daily dosage is 50 to 100 mg. in divided doses. Aldactone may be combined with a thiazide diuretic if necessary. Continue treatment for two weeks or longer since an adequate response may not occur sooner. Adjust subsequent dosage according to response of patient.

For edema, ascites or **effusions** in **adults** initial daily dosage is 100 mg. in divided doses. Continue medication for at least five days to determine diuretic response; add a thiazide or organic mercurial if adequate diuretic response has not occurred. Aldactone dosage should not be changed when other therapy is added. A daily dosage of Aldactone considerably greater than 75 mg. may be given if necessary.

A glucocorticoid, such as 15 to 20 mg. of prednisone daily, may be desirable for patients with extremely resistant edema which does not respond adequately to Aldactone and a conventional diuretic. Observe the usual precautions applicable to glucocorticoid therapy; supplemental potassium will usually be necessary. Such patients frequently have an associated hyponatremia—restriction of fluid intake to 1 liter per day or administration of mannitol or urea may be necessary (these measures are contraindicated in patients with uremia or severely impaired renal function). Mannitol is contraindicated in patients with congestive heart failure, and urea is contraindicated with a history or signs of hepatic coma unless the patient is receiving antibiotics orally to "sterilize" the gastrointestinal tract.

Glucocorticoids should probably be given first to patients with nephrosis since Aldactone, although useful for diuresis, will not directly affect the basic pathologic process.

For **children** the daily dosage should provide 1.5 mg. of Aldactone per pound of body weight.

References: **1.** Coodley, E. Consultant 12: 106-107, 109, 111, 113, 115 (July) 1972. **2.** Thorn, G. W., and Lauler, D. P. Am. J. Med. 53: 673-684 (Nov.) 1972

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Opinion & Dialogue

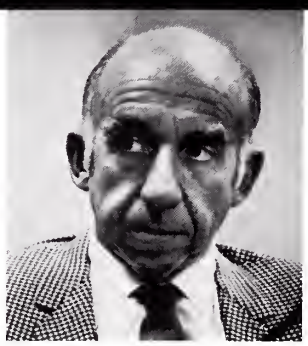
The Role of the Detail Man

Dr. Willard Gobbell
Family Physician
Encino, California

"I may be prejudiced, but I am very much in favor of the detail men I meet. Most of them are knowledgeable about the drugs they promote and can be a great help in acquainting me with new medication."

Family Physician's Perception

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most of the men who visit me regularly and they in turn have become aware of my particular interests and the nature of my practice. They, therefore, limit their discussion as much as possible to the areas of interest to me. Since I usually see the same representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date information about his products.



Dr. Jeremiah Stamler
Chairman
Department of Community Health and Preventive Medicine, and Dingman Professor of Cardiology
Northwestern University Medical School

"In the total picture of dealing with health problems in this country, there is a potential for detail men to play a meaningful role."

The Positive Influence

My contact with representatives and salesmen of the pharmaceutical industry is the type of contact that people in a medical center, research people, and academic people have and that's in all likelihood on a somewhat different level from that of the practicing physician.

Let me touch on how I personally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be—and at times actually are—disseminators of useful information. They could consistently serve a real educational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets—some of it scientifically sound and therefore truly useful—as well as some excellent films produced by the pharmaceutical industry. When they function in this

Is He a Source of Information?

Yes, with certain reservations. The average sales representative has a great fund of information about the drug products he is responsible for. He is usually able to answer most questions fully and intelligently. He can also supply reprints of articles that contain a great deal of information. Here, too, I exercise some caution. I usually accept most of the statements and opinions that I find in the papers and studies which come from the larger teaching facilities. It goes without saying that a physician should also rely on other sources for his information on pharmacology.

Training of Sales Representatives

Ideally, a candidate for the position as a sales representative of a pharmaceutical company should be a graduate pharmacist who has a questioning mind. I don't think this is possible in every case, and so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

---

capacity they are indeed useful; particularly in the fact that they disseminate broadly based educational material and serve not just as "pushers" of their drugs.

The Other Side of the Coin

Obviously, the pharmaceutical companies are not producing all this material as a labor of love—they are in the business of selling products for profit. In this regard the ambitious and improperly motivated sales representative can exert a negative influence on the practicing physician, both by presenting a one-sided picture of his product, and by encouraging the practitioner to depend too heavily on drugs for his total therapy. In these ways, the salesman has often distorted objective reality and undermined his potential role as an educator.

The Industry Responsibility

Since the detail man must be an information resource as well as a representative of his particular pharmaceutical company, he should be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.*, the patients—will be.

Physician Responsibility

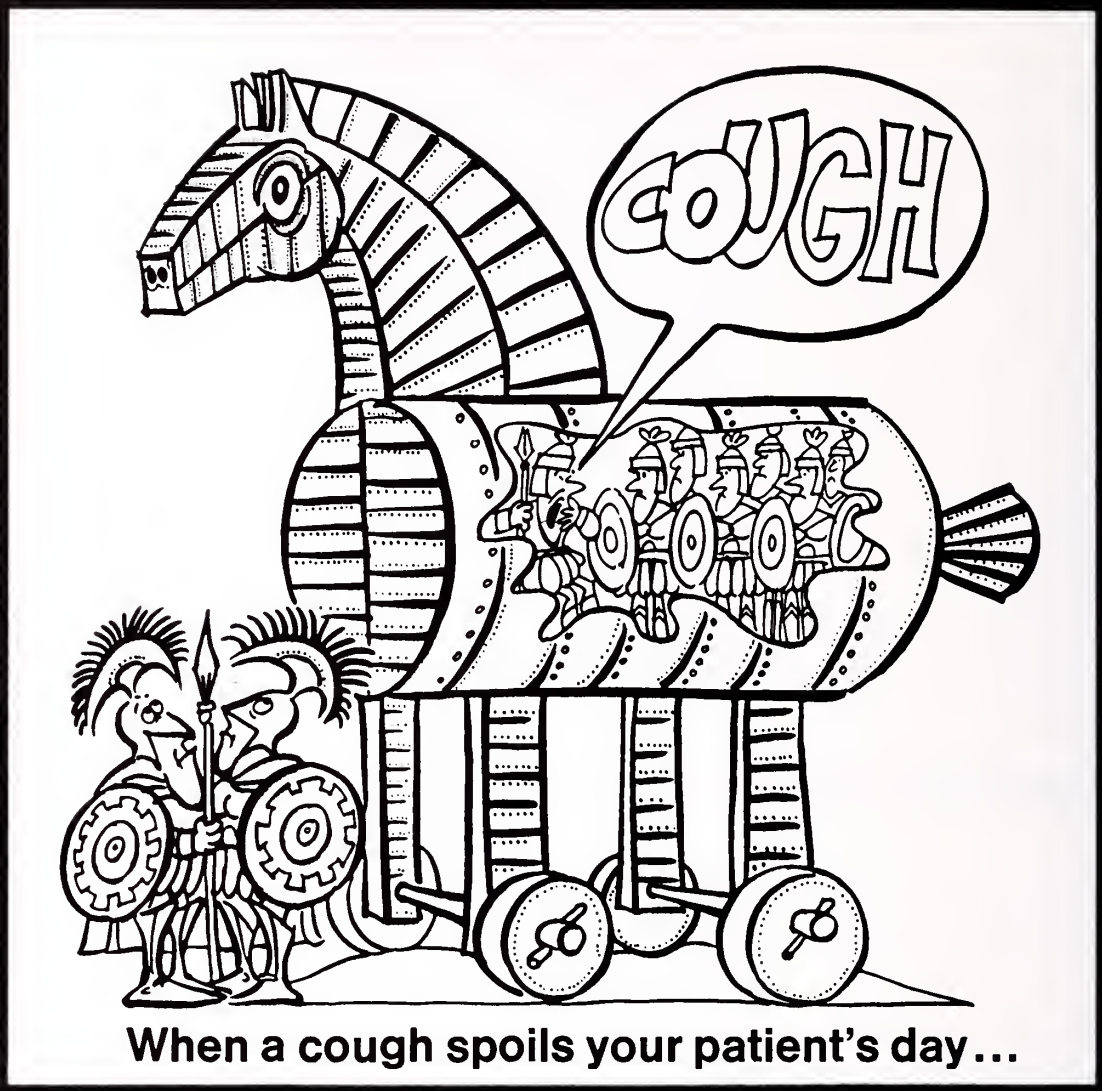
The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

P·M·A



When a cough spoils your patient's day...

Triaminic® Expectorant

Each teaspoonful (5 ml.) contains:

Triaminic, 25 mg. (phenylpropanolamine hydrochloride, 12.5 mg.; pheniramine maleate, 6.25 mg.; pyrilamine maleate, 6.25 mg.); glyceryl guaiacolate, 100 mg.; alcohol, 5%.

Available in 8-oz. Family Size and 4-oz.
No Rx needed—recommend over the phone.

The Adult Expectorant that is great for kids, too.

Dorsey Laboratories/Division of Sandoz-Wander, Inc./Lincoln, Nebraska 68501 BO-SD

In Memoriam

Justus J. Austin, MD
East Tawas

Justus James Austin, MD, East Tawas, died Aug. 5 at the age of 69. Doctor Austin had retired 10 years ago and had served as chief of staff at Tawas Hospital. A graduate of Wayne State University School of Medicine, he was former president of the Iosco County Medical Society.

Clyde H. Chase, MD
Grand Rapids

Clyde H. Chase, MD, former medical director of the J.L. Hudson Co., and long-time Harper Hospital, Detroit, staff member, died Aug. 2. He was 84. Doctor Chase was graduated from Western Reserve University, Cleveland, and served on the faculty of Johns Hopkins Medical School.

Charles F. Dodenhoff, MD
Grosse Pointe Farms

A general physician for 40 years, Charles F. Dodenhoff, MD, Gross Pointe Farms, died Aug. 30 at the age of 67. Doctor Dodenhoff was a graduate of Wayne State University School of Medicine and was affiliated with Deaconess and Saratoga General Hospitals. He was a member of the American Society of Abdominal Surgeons, and the International Board of Proctology. He also was a registered pharmacist.

August E. Gehrke, MD
Detroit

Retired Detroit otolaryngologist August E. Gehrke, MD, died Aug. 24 in St. Joseph Mercy Hospital, Pontiac. He had maintained a private practice in Detroit and was on the staff of Harper and Children's Hospitals. Doctor Gehrke was a graduate of the University of Michigan Medical School. He was 81.

Tyre K. Jones, MD
Formerly of Marshall

Retired Marshall generalist Tyre K. Jones, MD, died Aug. 25 at his summer home at Stony Lake, near Shelby. He made his winter home at Mt. Dore, Fla. Doctor Jones was 73. He was a graduate of the University of Nebraska medical school and served for 21 years as medical director of State Farm Insurance Co. He was on the staffs of Oaklawn Hospital of Marshall and the Battle Creek VA Hospital.

Roy Manty
Lansing

Roy Manty, the chief of the Division of Local Health Administration, Michigan Department of Public Health, died suddenly Aug. 13 at the age of 59.

John Bernhard Nill, MD
Grosse Pointe Park

A physician for 45 years in the Detroit area, John Bernhard Nill, MD, Grosse Pointe Park, died Aug. 31 at the age of 78. Doctor Nill was graduated from Wayne State University School of Medicine and was affiliated with Deaconess and St. Joseph Hospitals. He also was a director of the First State Bank of St. Clair Shores.

Arthur B. Norton, MD
Detroit

A Detroit physician for 56 years, Arthur B. Norton, MD, died Aug. 11 at the age of 82. Doctor Norton was graduated from the University of Michigan Medical School and served on the staff of Providence Hospital 40 years. After retirement, he served with the Columbia Hospital health service center.

Stanley Penzotti, MD
Lansing

A Three Rivers physician for over 25 years, Stanley Clare Penzotti, MD, died Aug. 17 at the age of 65. Doctor Penzotti had been with the Social Security medical determination office the past two years. Doctor Penzotti was graduated from Northwestern University medical school and had served on the staff of Three Rivers Hospital. He also had been an MSMS delegate for nine years and former president of the St. Joseph County Medical Society. In 1971 he received the Albion College Distinguished Alumni Award.

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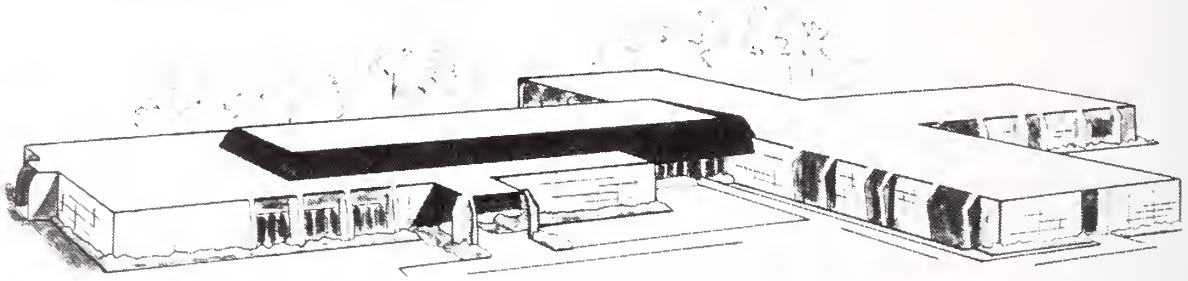
FOREST VIEW PSYCHIATRIC HOSPITAL



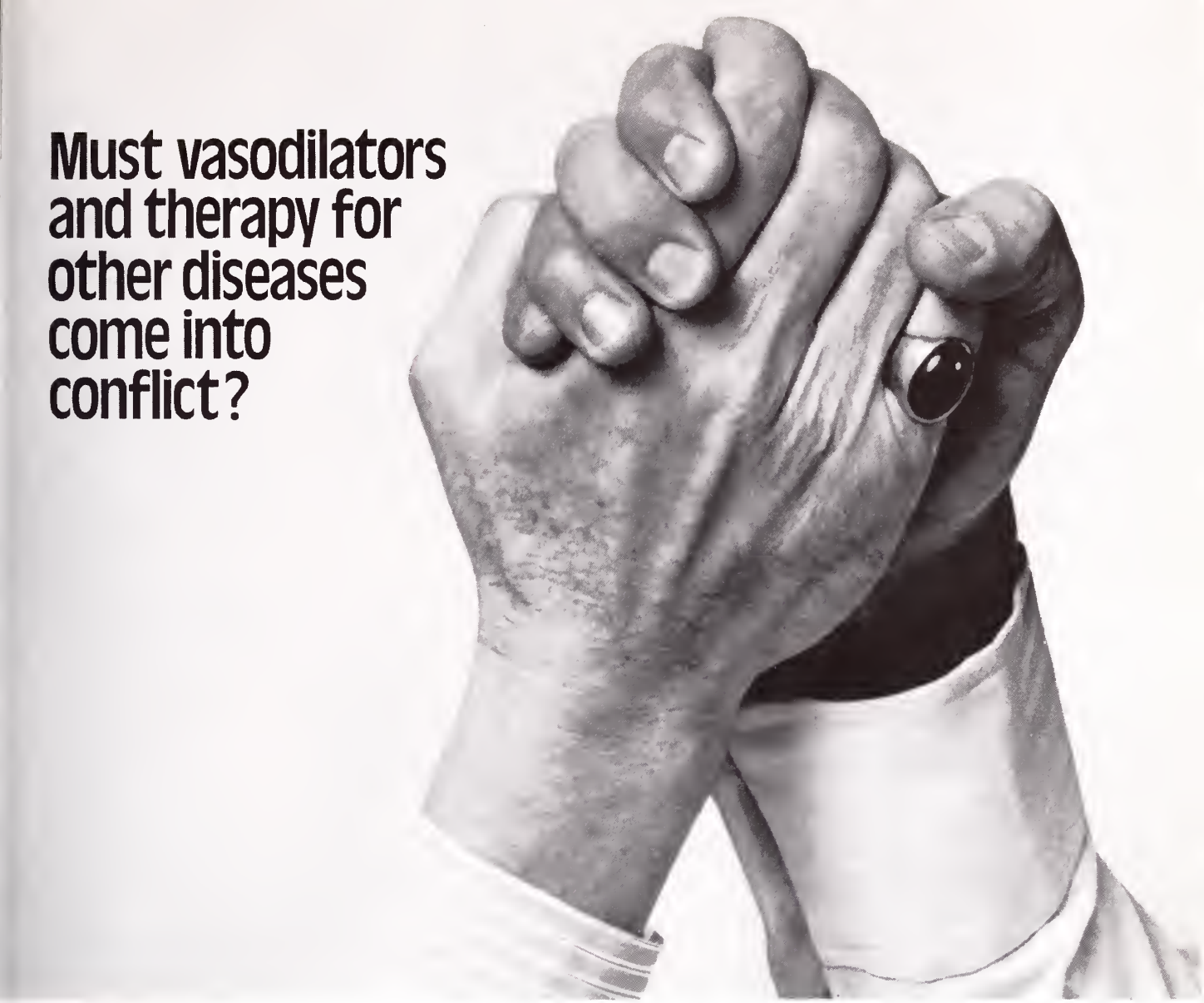
Charles L. Callaway MD, Medical Director

Located on six beautifully wooded acres, *FOREST VIEW HOSPITAL* is Michigan's newest private psychiatric facility, specializing in short term intensive treatment. Comprehensive adjunctive therapy, including occupational and recreational therapy is emphasized. The prime goal of the hospital personnel is to aid the patient in coping with his illness and return him to community life as soon as possible. Licensed by the State of Michigan, Department of Mental Health, Accredited by the Joint Commission of Accredation of Hospitals, Participant in Medicare and Medicaid.

Full Blue Cross participation.

4520 Cascade Rd. SE — Grand Rapids, Michigan 49506
Michael H. Payne, Administrator — 616-942-9610

Must vasodilators and therapy for other diseases come into conflict?



not if the vasodilator is

VASODILAN®
(ISOXSUPRINE HCl)

the compatible vasodilator... no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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The First Cardiovascular Symposium

Sponsored by

CHILDREN'S HOSPITAL OF MICHIGAN
Detroit Medical Center
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Wayne State University School of Medicine

NOVEMBER 7 and 8, 1974

featuring

DIAGNOSIS AND TREATMENT OF CONGENITAL HEART DISEASE

PROGRAM CHAIRMEN

Eduardo Arciniegas, M.D.
Chief of Cardiovascular Surgery

Edward Green, M.D.
Director of Medical Cardiology Services

GUEST SPEAKERS

Lionel Bargeron, M.D.
University of Alabama Medical Center
Birmingham, Alabama

Douglas Behrendt, M.D.
University of Michigan
School of Medicine, Ann Arbor

Aldo R. Castaneda, M.D.
Children's Hospital Medical Center
Boston, Massachusetts

James W. DuShane, M.D.
Mayo Clinic, Rochester, Minnesota

Donald Fyler, M.D.
Children's Hospital Medical Center
Boston, Massachusetts

Grady Hallman, M.D.
Texas Heart Institute
Houston, Texas

Dwight C. McGoon, M.D.
Mayo Clinic, Rochester, Minnesota

George Trusler, M.D.
The Hospital for Sick Children
Toronto, Ontario, Canada

PROGRAM

Friday, November 8
Infant Perfusion Techniques and Postop Management
Corrected Transposition
Ventricular Septal defect
Cardiac Tumors in Infancy
Coronary Artery Anomalies
Total Anomalous Pulmonary Venous Drainage
Endocardial Cushion Defects

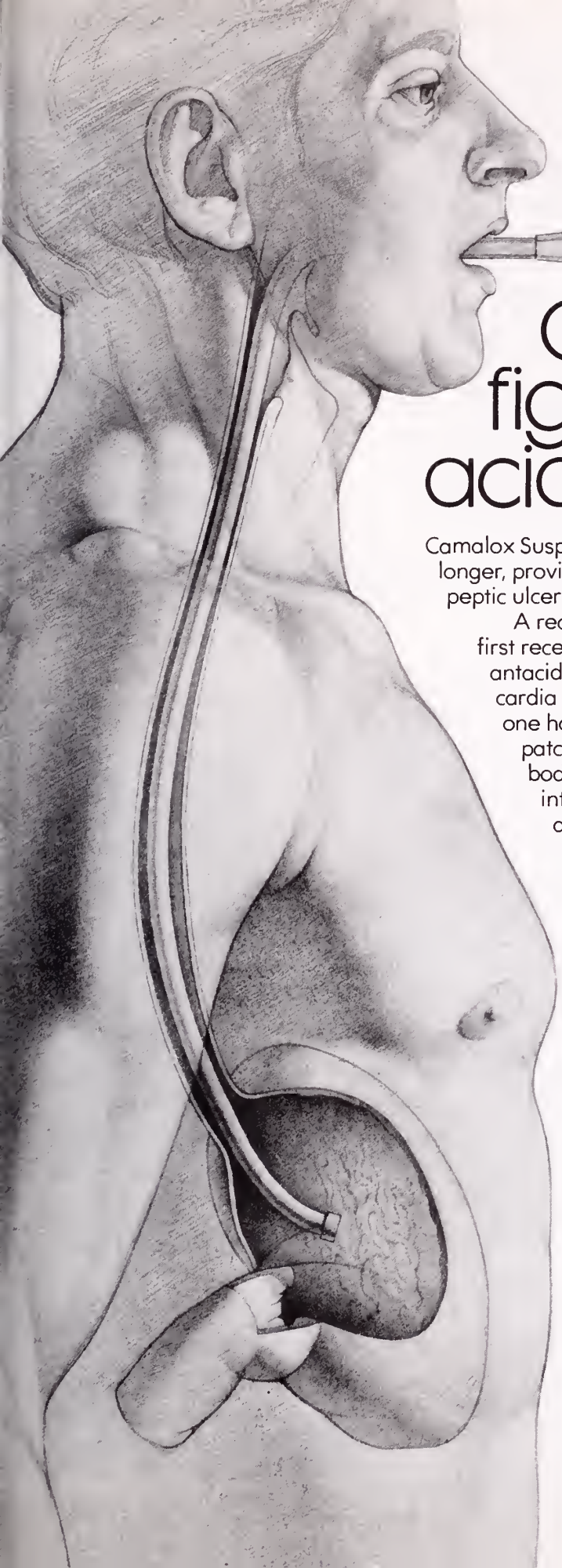
Thursday, November 7
Tetralogy of Fallot
Transposition of the Great Arteries
Double Outlet Right Ventricle
Tricuspid Atresia
Ebstein's Anomaly
Interrupted Aortic Arch
Truncus Arteriosus

REGISTRATION FEE: $75.00

Luncheon, Nov. 7-8: $6.00 each Cocktails & Banquet, Nov. 7: $10 per person
(Luncheon and Banquet reservations will not be accepted after October 31, 1974)

REGISTRATION OPENS 8:00 A.M. at CHILDREN'S HOSPITAL OF MICHIGAN
Detroit Medical Center
3901 Beaubien Boulevard
ADVANCE REGISTRATION ONLY Detroit, Michigan 48201

FOR ADDITIONAL INFORMATION CALL CHILDREN'S HOSPITAL (313) 494-5373



Camalox® fights excess acid longer.

Camalox Suspension, because it persists in the stomach longer, provides the prolonged antacid action your peptic ulcer patient needs.

A recent gastroscopic study of nine patients, who first received Camalox and then a leading competitive antacid, revealed that only Camalox persisted in the cardia portion of the stomach throughout the test, at one hour post-ingestion—and in the form of flecks, patches, clumps or coating in the antrum and the body of the stomach, depending on the time interval and the dosage. Only very spotty adherence of the competitive antacid was observed at 10 minutes, and hardly any at 30 and 60 minutes.

These findings come as no surprise, for they correlate with earlier *in vitro* test results of Camalox Suspension effectiveness. Camalox Suspension kept the pH above 3.5 for 120 minutes, versus 93 minutes for its nearest competitor.

When excess gastric acid overwhelms your ulcer patient, he needs an antacid that neutralizes longer, faster, and effectively. He needs Camalox, the antacid with hour power.

Longer-acting **Camalox®**

magnesium and aluminum hydroxides with calcium carbonate

The high potency antacid

WILLIAM H. RORER, INC.
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MICHIGAN STATE MEDICAL SOCIETY

AFRICAN ADVENTURE

INVITES YOU TO SPEND TWO SUN-FILLED WEEKS IN RABAT, CASABLANCA AND NAIROBI

IT'S NOT TARZAN, JANE AND CHEETAH

It's more than a trip.

A lot more . . . Atlantic white beaches, majestic mountains, cosmopolitan cities, restaurants with French and International cuisine, bargains in brassware, jewelry, leather, carpets, safari filming, tropical scenery green and cool. It's all here, a carefree, do-as-you-please holiday in Africa.

It's more than a bargain.

$1168

Includes: direct chartered jet flights, deluxe hotels, American breakfasts, gourmet dinners at a selection of the finest restaurants, transfers and a generous 70 lb. luggage allowance.

DEPARTING DETROIT
FEBRUARY 3, 1975

SEND TO:

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Enclosed is my check for $_____
($100 per person) as deposit.

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Another non-regimented INTRAV deluxe adventure

Healing nicely, but it still HURTS

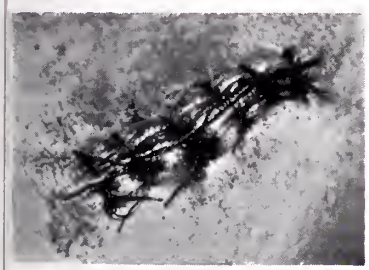
EMPIRIN® COMPOUND c̄ CODEINE

#3, codeine phosphate* (32.4 mg.) gr. ½
#4, codeine phosphate* (64.8 mg.) gr. 1

HERE Burns

When parenteral analgesia is no longer required, Empirin Compound with Codeine usually provides the relief needed.

HERE Sutures

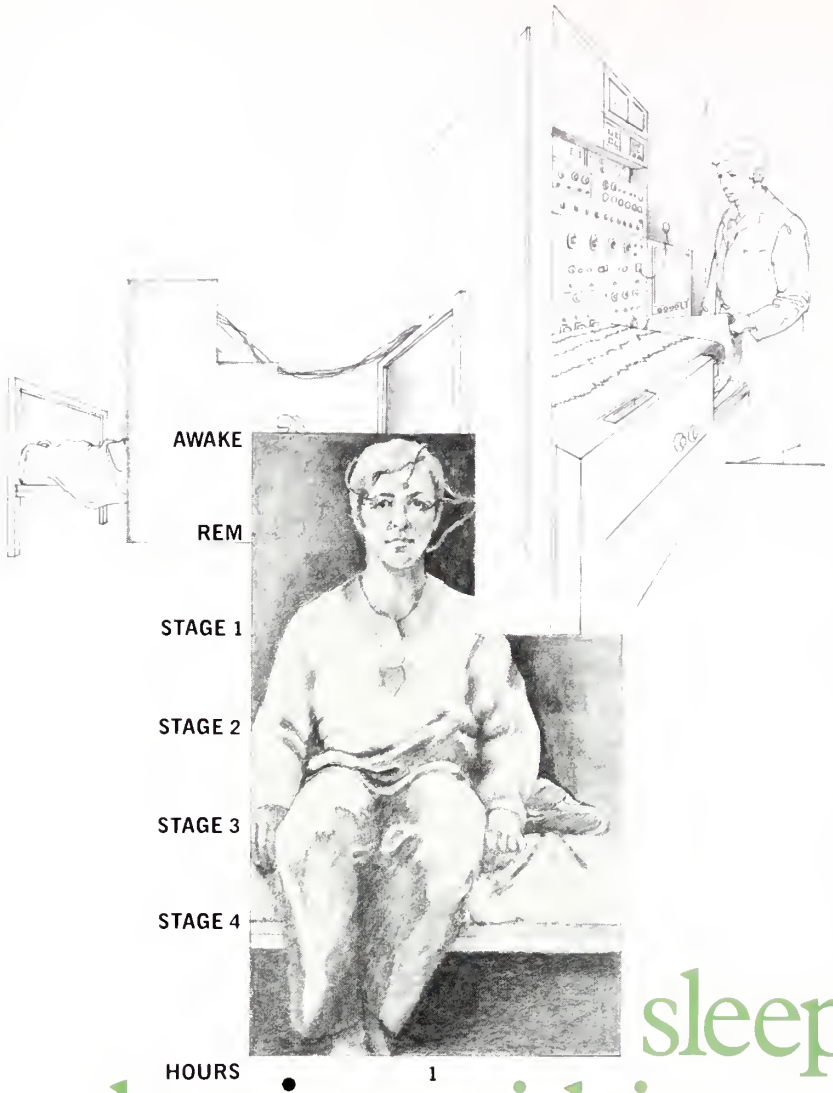


Empirin Compound with Codeine is effective for visceral as well as soft tissue pain—provides an antitussive bonus in addition to its prompt, predictable analgesia.

Ⓒ III **prescribing convenience:** up to 5 refills in 6 months, at your discretion (unless restricted by state law); by telephone order in many states.

Empirin Compound with Codeine **No. 3,** codeine phosphate* 32.4 mg. (gr. ½); **No. 4,** codeine phosphate* 64.8 mg. (gr. 1).*Warning—may be habit-forming. Each tablet also contains: aspirin gr. 3½, phenacetin gr. 2½, caffeine gr. ½.

Wellcome / **Burroughs Wellcome Co.**
Research Triangle Park
North Carolina 27709

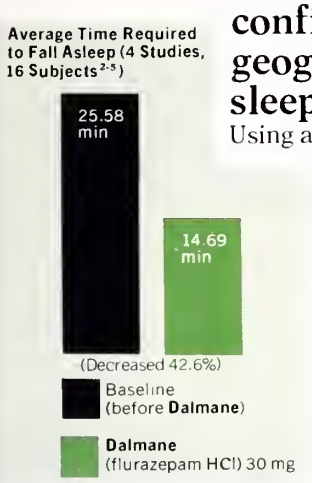


sleep begins within 17 minutes, on average ... an initial benefit of

Dalmane®
(flurazepam HCl)

proved by a 22-night clinical study of insomnia patients in the sleep research laboratory and at home[1]

Three insomnia patients selected for difficulty falling asleep were administered Dalmane (flurazepam HCl) 30 mg for 14 consecutive nights. Placebo was given for four nights prior to and four nights after Dalmane. Physiologic tracings on Dalmane nights 1-3 showed sleep induction time averaged 13.90 minutes; on Dalmane nights 12-14, 18.80 minutes. Combined average for the 6 monitored drug nights was 16.35 minutes.[1]


Average Time Required to Fall Asleep (4 Studies, 16 Subjects[2-5])
25.58 min
14.69 min
(Decreased 42.6%)
Baseline (before Dalmane)
Dalmane (flurazepam HCl) 30 mg

confirmed by clinical studies in four geographically separated sleep research laboratories[2-5]

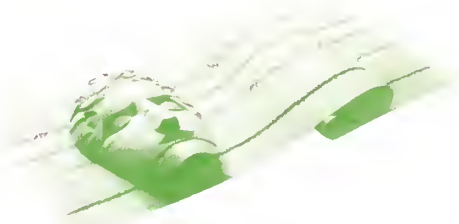
Using a 14-night protocol involving eight insomniac and eight normal subjects, four studies confirmed the sleep-inducing effectiveness of Dalmane (flurazepam HCl) and the reproducibility of this response. On average, one 30-mg capsule induced sleep within 17 minutes. In all these studies, Dalmane induced sleep rapidly, reduced nighttime awakenings, and provided 7 to 8 hours of sleep without repeating dosage[2-5]

Dalmane (flurazepam HCl) induces and maintains sleep, with relative safety

Dalmane is generally well tolerated; morning "hang-over" has been relatively infrequent. While dizziness, drowsiness, lightheadedness and the like have been noted most often, particularly in the elderly and debilitated, physicians should be aware of the possibility of more serious reactions, as noted below.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.
Contraindications: Known hypersensitivity to flurazepam HCl.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.
Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.
Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.
Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.
Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



when restful sleep is indicated

Dalmane®
(flurazepam HCl)

One 30-mg capsule *h.s.* — usual adult dosage (15 mg may suffice in some patients).
One 15-mg capsule *h.s.* — initial dosage for elderly or debilitated patients.

- induces sleep within 17 minutes, on average
- reduces nighttime awakenings
- sustains sleep 7 to 8 hours, on average, without repeating dosage

REFERENCES: 1. Kales A, *et al*: *Arch Gen Psychiatry 23*:226-232, Sep 1970
2. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971
3. Frost JD Jr: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
4. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
5. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ

ROCHE

ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
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Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

Indications: Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. Also, mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: **Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, descreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles and Single Unit Packages of 100 capsules.

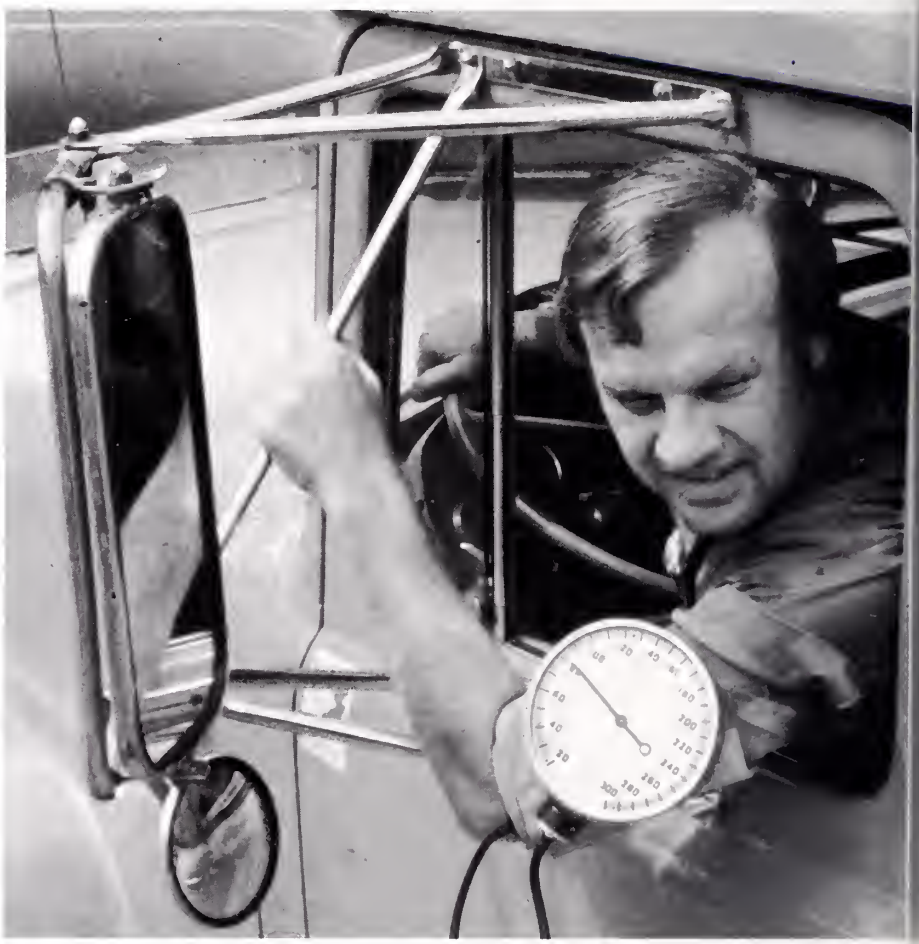
SK&F CO.
Carolina, P.R. 00630
Subsidiary of
SmithKline Corporation

KEEP THE HYPERTENSIVE PATIENT ON THERAPY
KEEP THERAPY SIMPLE WITH
DYAZIDE®

Trademark

Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

No potassium supplements
No special K^+ rich diets
Just 'Dyazide' once daily or twice daily



Studies have demonstrated that two prime reasons patients drop out of hypertensive therapy are: (1) the patient failed to understand directions, and (2) the regimen was overly complicated.* Dosage is simple with 'Dyazide', easily understood, once or twice daily, depending on response. There's no need to complicate the regimen with potassium supplements or unwieldy potassium-rich diets.

*E.D. Freis: The Modern Management of Hypertension, V.A. Information Bulletin, 11-35.

TO KEEP BLOOD PRESSURE DOWN AND KEEP POTASSIUM LEVELS UP

Maybe the patient's self-diagnosis is right. He could have hay fever. But that bright red nasal mucosa, along with the thick discharge and excoriation around the nares, strongly suggests that the main problem is a cold. Hay fever or another form of allergic rhinitis may or may not be an underlying factor.

If a complete history and examination rule out allergic rhinitis, the long-term outlook will be a lot more favorable than his own "diagnosis" would have indicated.

But right now, whether he's got allergic rhinitis or a cold, he's suffering from the same irritating symptoms of drip, congestion and stuffiness. Try DIMETAPP EXTENTABS®. They're formulated to relieve these symptoms without much chance of causing drowsiness or overstimulation. Your patients will appreciate the 24-hour relief they can get from just one tablet every 12 hours.

Cold or

Allergy?

Whether it's a cold or an allergy, Dimetapp Extentabs® effectively relieve stuffiness, drip and congestion.

INDICATIONS: Dimetapp Extentabs are indicated for symptomatic relief of allergic manifestations of upper respiratory illnesses such as the common cold, seasonal allergies, sinusitis, rhinitis, pharyngitis, tonsillitis and others in these cases it quickly reduces inflammation and edema, nasal congestion and excessive upper respiratory secretions, thereby effecting relief from nasal stuffiness and postnasal drip.

CONTRAINDICATIONS: Hypersensitivity to antihistamines. If the patient is receiving a monoamine oxidase inhibitor. Dimetapp Extentabs are contraindicated during pregnancy and in children under 12 years of age. Because of its drying and thickening effect on bronchial respiratory secretions, Dimetapp is not recommended in the treatment of bronchial asthma. Also, Dimetapp Extentabs are contraindicated in patients receiving MAO inhibitor therapy.

WARNINGS: Use in children under 6 years

Dimetapp Extentabs®

Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.

A·H·ROBINS

A. H. Robins Company, Richmond, Va. 23220

when pain goes on... and on... and on–

For the patient with a terminal illness, PAIN past, present, and future can dominate his thoughts until it becomes almost an obsession. The more he is aware of the pain he is now experiencing, the more difficult it is to erase his memory of yesterday's pain, and to allay his fearful anticipation of tomorrow's pain.

Surely the last thing this patient needs is an analgesic containing caffeine to stimulate the senses and heighten pain awareness. A far more logical choice is Phenaphen with Codeine. The sensible formula provides ¼ grain of phenobarbital to take the nervous "edge" off, so the rest of the formula can help control the pain more effectively. Don't you agree, Doctor, that psychic distress is an important factor in most of your terminal and long-term convalescent patients?

the analgesic formula that calms instead of caffeinates

Phenaphen® with Codeine

Phenaphen with Codeine No. 2, 3, or 4 contains: Phenobarbital (¼ gr.), 16.2 mg. (warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Codeine phosphate, ¼ gr. (No. 2), ½ gr. (No. 3) or 1 gr. (No. 4) (warning: may be habit forming)

Indications: Provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products, excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.

(III) Phenaphen with Codeine is now classified in Schedule III, Controlled Substances Act of 1970. Available on written or oral prescription and may be refilled 5 times within 6 months, unless restricted by state law.

A. H. Robins Company, Richmond, Va. A·H·ROBINS

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Michigan Doctors Political Action Committee

Box 769, East Lansing, Michigan 48823

October, 1974

Dear Doctor:

The Michigan Doctors Political Action Committee believes that one of the most important rights inherent to all Americans is the right to vote. Unfortunately, many of your elderly, ill or handicapped patients are prevented from exercising this right because of their inability to get to the polls on election day.

In order to help your patients who may experience this difficulty in Michigan's general election November 5, this issue of Michigan Medicine carries a special MDPAC Educational package of absentee voter applications and how to use them.

To help your patients exercise their rights without undue effort or hardship, will you display the enclosed poster (opposite this letter) in your office, and make available to them the enclosed absentee ballot applications?

Also enclosed is an instructional sheet that your office personnel might want to use as a reference to assist anyone in completing the application.

The absentee ballot applications have been approved by the Secretary of State. If you require additional applications they may be obtained from the MDPAC staff by calling MSMS headquarters -- (517/337-1351).

Thank you for your assistance with this educational project. Don't forget to remind your family and office personnel to vote November 5.

The cost of making this package available to you and your patients is paid completely from MDPAC Educational Funds. No MDPAC dues monies have been used as such funds are reserved for political contributions.

MDPAC Louis R. Zako, MD, Dearborn Heights (chairman)
Thomas R. Berglund, MD, Portage (secretary-treasurer)

Copies of our reports, filed with the appropriate supervisory officer, are available for purchase from the Superintendent of Documents, United States Government Printing Office, Washington, D.C. 20402.

DON'T GIVE UP YOUR RIGHT TO VOTE

on

TUESDAY, NOVEMBER 5th

STATE LAW ALLOWS

ABSENTEE VOTING

- **YOU ARE 62 YEARS OF AGE OR OLDER**
- **PHYSICALLY UNABLE TO ATTEND THE POLLS WITHOUT ASSISTANCE**
- **A POSSIBLE TRIP ON ELECTION DAY**

Indicates a *probable* need for an....

ABSENT VOTER BALLOT

It's so Simple! Just phone your City or Township Clerk and Request an "Application for Absent Voter Ballot." Complete it and return it to the same Clerk by Mail.

OR

Ask at Registration Desk for an Application!

Complete it! Sign it! Mail it to Your Clerk!

The person who says that he is above politics is really saying that democracy is beneath him.

Meet the challenge. Support your democracy.

Pay your $25 dues now to

MDPAC, Box 769,

East Lansing 48823.

(The Michigan Doctors Political Action Committee is a voluntary unincorporated, bi-partisan committee of physicians and others interested in the improvement of government by encouraging qualified candidates to run for elective office.)

Established 1924

MERCYWOOD HOSPITAL

4038 Jackson Road **Conducted by Sisters of Mercy** **Ann Arbor, Michigan**

Telephone — 313 663-8571

Mercywood Hospital is a private neuropsychiatric hospital licensed by the Michigan Department of Mental Health. Mercywood specializes in intensive, multi-disciplinary treatment for emotional and mental disorders.

Accredited by the Joint Commission on Accreditation of Hospitals and the National League of Nursing. A full Blue Cross participating hospital.

Certified for: Medicare and M.A.A. programs

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Prehlad S. Vachher, M.D.
Richard D. Watkins, M.D.
Robert M. Zimmerman, M.D.

INSTRUCTIONS
for assisting in completing an application for an Absentee Ballot

Application for Absent Voters Ballot

Filed _____, 19____ Received Ballots Herein Described

Ballot No._____ _____, 19____

Mailed_____, 19____

Returned _____, 19____ _____
(Chairman Board of Election Inspectors)

_____ _____
(Clerk) (Ward) (Precinct)

FOR THE *GENERAL* ELECTION TO BE HELD ON NOVEMBER 5, 1974

I, _____, a duly qualified
(Print Full Name)

and registered elector of the _____Ward/District _____Precinct of the
(Give number of Ward and Precinct if more than one)

☐ CITY ☐ TOWNSHIP of _____
(Check One) (Name of City or Township)

in the County of _____and
State of Michigan, hereby make application for an official ballot, or ballots, to be voted by me at such election.

THE STATUTORY GROUNDS ON WHICH I BASE MY REQUEST ARE
(Check Applicable Reason)

- ☐ I am 62 years of age or older.
- ☐ I expect to be absent from the community in which I am registered for the entire time the polls are open on election day.
- ☐ I am physically unable to attend the polls without the assistance of another.
- ☐ I cannot attend the polls because of the tenets of my religion.
- ☐ I have been appointed an election precinct inspector in a precinct other than the precinct where I reside.

Send "Absent Voter's Ballot" to me at

_____
(Number) (Street)

City_____ State _____ Zip_____

My registered address is_____
(Number) (Street)

(I hereby declare the foregoing statements to be true)

Date_____ X_____
(Signature of Absent Voter)

WARNING: Any person making a false statement in this declaration upon conviction shall be guilty of a misdemeanor.

- RETURN THIS APPLICATION TO YOUR TOWNSHIP OR CITY CLERK.

THIS APPLICATION NOT VALID LATER THAN 2:00 P.M. OF THE SATURDAY PRECEDING PRIMARY OR ELECTION DAY.

- IT IS SUGGESTED THAT YOU MAIL THIS APPLICATION AS SOON AS POSSIBLE.

1. PRINT full name as you are registered.
2. Give Ward No. if your community has Wards – otherwise, leave blank.
3. Give Precinct No. if known. Otherwise, leave blank.
4. Check One – Are you registered in a City or a Township?
5. Give Name of the City or Township.
6. Name of County in which you reside.
7. Check appropriate box.
8. Where do you want your ballot sent?
9. At what address are you registered? If same as Item 8, write "Same as Above."
10. Date and Sign! Sign your Name the way you are registered.
11. Send this Application to the Clerk named in Item 4 & 5.

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_____
(Clerk)

Received Ballots Herein Described

_____, 19____

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(Chairman Board of Election Inspectors)

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(Ward) (Precinct)

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When **impotence** *due to*

androgenic deficiency

is driving them apart

Android®-5 MUQETS BUCCAL Tabs

Android®-10 ORAL Tabs

Android®-25 ORAL Tabs

Methyltestosterone N.F. — 5, 10, 25 mg.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpuberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

Write for Literature and Samples

BROWN **THE BROWN PHARMACEUTICAL CO., INC.**

2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

HOSPITAL & MEDICAL PLANNING, INC.
702 Abbott Road
East Lansing, Michigan
48823
517 332-1333

ATTENTION

GENERAL PRACTITIONERS
SURGEONS
INTERNISTS — PEDIATRICIANS

We are searching for two Physicians to join an Emergency Group serving a 500-bed hospital located in a medium-sized city in Northeast Ohio. Group is headed by Board Internist. Congenial atmosphere. Prior experience as Emergency Room Physician not required. Change your life-style to a more normal and regular schedule with considerably more worry-free time off for yourself and family. Starting annual level is $50K with increases in succeeding years — plus other benefits of corporate group. Interested physicians may call or send their curriculum vitae in confidence and with no financial obligation to Arthur A. Lepinot.

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Classified Advertising

$5.00 per insertion of 50 words or less, with an additional 10 cents per word in excess of 50.

IMMEDIATE OPENING for Ob-Gyn, Internal Medicine, specialties to establish successful practice with 14-man multi-specialty group. Excellent group benefits; pension plan; modern clinic facilites; progressing community with excellent educational system including two colleges; city population 35,000; good recreational facilities; each specialty must be board eligible or certified. Contact Business Manager, The Manitowoc Clinic, 601 Reed Ave., Manitowoc, Wisconsin 54220.

NEWBERRY — Luce County needed General Practitioners in beautiful upper peninsula hospital — 60 miles west of the Mackinac bridge. A fully accredited hospital with excellent staff. Contact: D. J. Massoglia, Administrator — Helen Newberry Joy Hospital, Newberry, Michigan. Phone (906) 293-5181.

OB-GYN with a well established 15-man Medical Surgical Group in Detroit. Minimum guarantee of $50,000 for first year with growth and security for future years. Reply Box #1, 120 West Saginaw St., East Lansing, Michigan 48823.

DIRECTOR OF INTERNAL MEDICINE UNDERGRADUATE EDUCATION: Flint Campus-MSU-College of Human Medicine seeking academically oriented Generalist or Subspecialist to be responsible for implementing undergraduate medicine programs in 3 community hospitals. Must be good teacher. Tenured faculty appointment. Excellent salary and fringe benefits. Contact: D. Mulkey, M.D., Assitant Dean, 302 Kensington, Flint, Michigan 48502. Phone (313) 238-6581.

ALPENA: Psychiatrist in Comprehensive Community Mental Health Center, inpatient, outpatient, consultation and education preventive emphasis. Michigan license required. Alpena offers an excellent school system and unlimited recreational opportunities such as fishing, hunting, skiing, camping, snowmobiling. A scenic rural setting with a progressive high quality of practice, salary is competitive and negotiable, excellent fringe benefits. Write Ali Guner, M.D., Psychiatric Mental Health Centers, Inc. 1521 W. Chisholm St., Alpena, Michigan 49707. An equal opportunity employer. An affirmative Action Policy.

LAKE MICHIGAN FRONTAGE. Upper Peninsula, hour from Mackinac Bridge. 2100 feet sand beach, surrounded by State forest. Road available into tract. An investment you can enjoy while water frontage values increase. Map and details available. Vacationland Realty, 407 Northland Towers, West, Southfield, MI 48075 (313) 353-6302.

MARCO ISLAND, Florida — Exclusive gulf beachfront condominium; 14 miles south of Naples — two bedroom, two bath 14th floor corner apartment with a private wraparound balcony, completely furnished, sleeps six. 3 mile white sand beach, shelling, fishing, golf, tennis. Available by month, but seasonal lease preferred. Phone (202) 245-4599 weekdays or write Box 10, 120 W. Saginaw St., East Lansing, MI 48823.

GENERAL PRACTICE AVAILABLE. An excellent building with equipment for clinic or multiple Doctor occupancy. Situation provides perfect opportunity for a starting family physician or the combining of an existing practice for need of larger facilities and relocation. For information write to 330 Lothrop Rd., Grosse Pte. Farms, MI 48236 or call (313) 881-1677 or 882-3232.

WANTED: Board certified or eligible pediatrician to join two man incorporated pediatric practice in Western Michigan city. Year around recreational facilities. Contact: Pediatric Associates, P.C. 1643 Peck St., Muskegon, MI 49441.

WANTED: Immediate opening for Staff Physician with or eligible for Michigan License for fully accredited 354-bed hospital for the care of rehabilitation, tuberculosis, psychiatric and chronic disease patients. Excellent salary and fringe benefits. 40 hours week. Reply: Personnel Office, Saginaw Community Hospital, 3340 Hospital Road, Saginaw, Michigan 48605.

CHIEF MEDICAL OFFICER for VA Outpatient Clinic located in Grand Rapids, Michigan. Board eligibility in Internal Medicine or Psychiatry preferred. Must be licensed in U.S. Clinic will have full complement of nurses, social workers, psychologists, pharmacists, and administrative support. Regular duty hours and usual Federal employee fringe benefits including 30 days vacation, 15 days sick leave, and 9 paid holidays per year plus low cost health insurance, and excellent retirement plan. Salary $25,863 - $36,000, depending on qualifications. Contact: Bryant H. Roisum, M.D., Chief of Staff, VA Hospital, Battle Creek, Michigan. Phone (616) 965-3281, Ext. 581. AN EQUAL OPPORTUNITY EMPLOYER.

PHYSICIAN WANTED to work as team member of a Substance Abuse Unit in a large neuropsychiatric hospital. Must be interested in working with patients having problems with drugs or alcohol. May be generalist or trained in psychiatry or internal medicine. Must have license in U.S. Hospital has active, expanding program with Michigan State University affiliation anticipated in the near future. Regular hours and usual Federal employee fringe benefits, including 30 days vacation, 15 days paid sick leave, 9 paid holidays per year, plus low cost health insurance and excellent retirement plan. Salary $25,863 to $36,000, depending on qualifications. Contact Bryant H. Roisum, M.D., Chief of Staff, VA Hospital, Battle Creek, Michigan. Phone (616) 965-3281, Ext. 581. AN EQUAL OPPORTUNITY EMPLOYER.

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respond to one

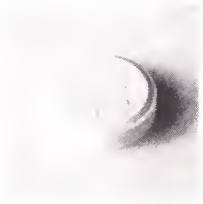
According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

For further information on this subject, the following references are provided:

1. Henry BW, *et al: Dis Nerv Syst 30*:675-679, Oct 1969.
2. Hollister LE, *et al: Arch Gen Psychiatry 24*:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970.



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in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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The cover photo this month is by Will Tishkoff, son of G. H. Tishkoff, MD, East Lansing, using yellow filter, Ektachrome film and an Olympus 35 mm Rangefinder camera.

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Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. In editorials, the views expressed are those of the writer and not necessarily official positions of the society.

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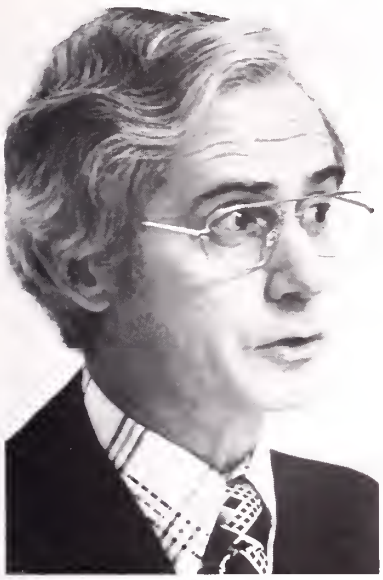


Doctor Masters

Michigan Blue Cross – Blue Shield Are One!

DETROIT (AP) — Blue Cross and Blue Shield, Michigan's two largest health care plan organizations, announced plans to merge the groups by the end of the year in a statement Saturday (July 13).

It was just a moment in the history of health care in Michigan. But to many like myself it was a poignant one. To those of us who remember when the Michigan State Medical Society led the way in the establishment of Blue Shield in 1939; when all doctors faced assessments and even forgave their fees just to keep the "baby alive"; when, even then, the movement was an idea to make health care a respectable business proposition for all; when all through the years the doctors and hospitals agreed to keep their payment mechanisms separate — such a moment seemed inconceivable even a few years ago.

But this is 1974 and the only certain thing in our world is change. Both boards now are publicly controlled. Both organizations are still the leaders in the voluntary prepayment plans for health care (who is to deny that their strength has delayed national health insurance for years?). As such, efficiency and common sense dictated this merger. The unanimous vote (minus one) of both boards reflected this consensus.

Now, it is a whole new ball game. Hopefully, both teams will put their best batters in the line-up!

This is a golden opportunity for us in the medical profession to recognize the role of hospitals in today's delivery of health care, and together build a foundation that will strengthen private practice in the years to come. We must not fear the hospital-salaried physician or the emergency room as a developing center for health care delivery. But we must recognize that these, and others, are facts of life today. Also we must lend our support and expertise to guide these movements so they might achieve their proper place in the total rubric of this system we are such an integral part of.

I trust doctors will not actively believe that this merger will mean that Blue Cross will "take over" Blue Shield. Let us, instead, consider this event a recognition that private enterprise today requires this joining of forces, and volunteer our active support to make this new "Blue Team" an even more effective voice in the voluntary prepayment system.

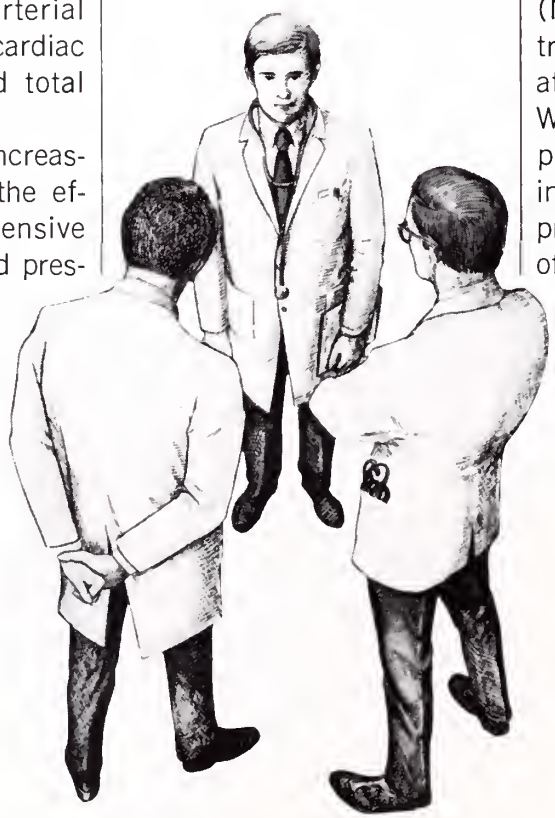
If we do, I predict that July 13, 1974 will be marked in history as another step forward in the free practice of medicine and health care delivery in Michigan.

Brooker L. Masters, MD

The more physicians consider the hemodynamics of lowering blood pressure...

Most physicians now agree on the importance of reducing blood pressure in the hypertensive patient. But high blood pressure exists, of course, only as part of a complete clinical picture. The hemodynamic profile of well-established essential hypertension is characterized by elevated arterial blood pressure, normal cardiac output, and increased total peripheral resistance.

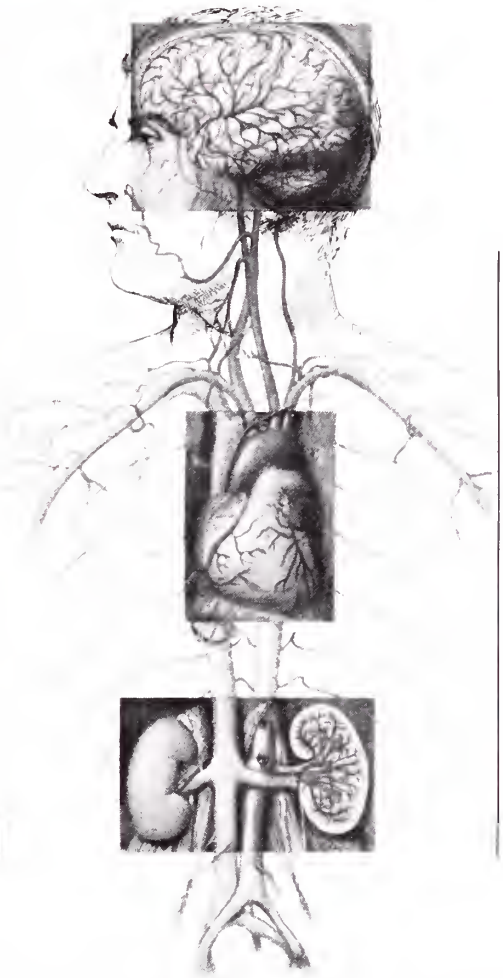
And so, physicians are increasingly concerned with the effects of an antihypertensive agent not only on blood pressure itself but also on the hemodynamic pattern—in short, with the total effect of the drug. *Does* it indeed help lower blood pressure effectively? *Is* peripheral resistance reduced? *Are* cardiac output and renal functions maintained? And, also, is there likely to be drug-induced postural hypotension serious enough to pose a threat to the patient's cerebrovascular status?



With this emphasis on overall drug performance has come a growing reliance on ALDOMET® (Methyldopa, MSD) in the treatment of sustained moderate hypertension.

With its unique hemodynamic profile, ALDOMET has drawn increasing attention and approval from physicians. First, of course, for its efficacy in

the more physicians rely on this unique antihypertensive



lowering blood pressure. But there are other considerations as well. Cardiac output is usually maintained with no cardiac acceleration; in some patients the heart rate is actually slowed. Peripheral resistance is apparently reduced. ALDOMET does not usually compromise existing renal function; it generally does not reduce renal blood flow, glomerular filtration rate, or filtration fraction. And ALDOMET usually does not cause symptomatic postural or exercise hypotension.

Contraindications include active hepatic disease and known sensitivity to the drug. Use with caution in patients with a history of liver disease or dysfunction. Not recommended in pheochromocytoma or pregnancy.

It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. For more details see the brief summary of prescribing information.

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In most cases of sustained moderate hypertension

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smoothly lowers blood pressure

Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis. Known sensitivity. Not recommended in pheochromocytoma. Unsuitable in mild or labile hypertension responsive to mild sedation or thiazide therapy. Use cautiously in patients with history of previous liver disease or dysfunction.

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between six and twelve months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at six and twelve months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first three weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first two to three months of therapy. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first six to twelve weeks of therapy or whenever an unexplained fever occurs. If fever, abnormalities in liver function tests, or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, reversible reduction in leukocyte count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur.

Use in Pregnancy and Childbearing Age—Not recommended in pregnancy. In women of childbearing age, weigh potential benefits against possible fetal hazards.

Precautions: Methyldopa may interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, spuriously high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has occurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: Sedation, usually transient, may be seen during initial therapy or when dosage is increased. Headache, asthenia, or weakness may be noted as early, transient symptoms. Symptoms associated with effective lowering of blood pressure are occasionally seen and include dizziness, lightheadedness, and symptoms of cerebrovascular insufficiency. Angina pectoris may be aggravated. Symptoms of orthostatic hypotension may occur; if symptoms occur, reduction of dosage is suggested. Bradycardia, nasal stuffiness, mild dryness of mouth, and gastrointestinal symptoms including distention, constipation, flatus, and diarrhea occur occasionally; these generally can be relieved by reducing dosage. Nausea and vomiting have been reported in only a few patients. Sore tongue or "black tongue," pancreatitis, and inflammation of salivary glands may occur.

Weight gain and edema occur infrequently and are relieved by administering a thiazide diuretic; if edema progresses or signs of pulmonary congestion appear, discontinue drug. A rise in BUN has been observed. Other rare reactions include breast enlargement, lactation, impotence, decreased libido, skin rash, mild arthralgia, myalgia, paresthesias, Bell's palsy, parkinsonism, psychic disturbances including nightmares, reversible mild psychoses or depression. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Note: Dosage should be limited initially to 500 mg daily when following previous antihypertensive agents other than thiazides. Maximal recommended daily dose is 3.0 g. Patients with impaired renal function may respond to smaller doses than patients with normal kidney function. Syncope in older patients has been related to increased sensitivity in those with advanced arteriosclerotic vascular disease; this may be avoided by lower doses. Tolerance occasionally seen either early or late, but more likely between second and third month after initiation of therapy; increased dosage or combined therapy with a thiazide frequently restores effective control.

How Supplied: Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100.

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addendum

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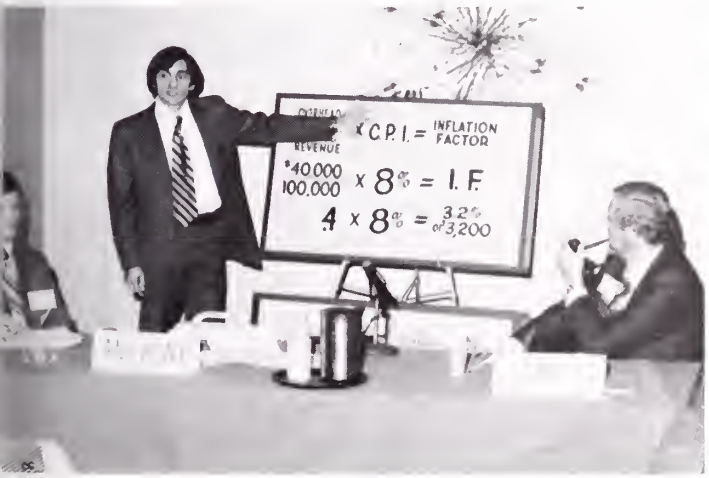
Please ask your Merck Sharp & Dohme Professional Representative or write Professional Service Department, West Point, Pa. 19486 for a supply of this booklet.

The 1974 MSMS Scientific Meeting: Photos

Over 1,000 Michigan physicians gathered at the Sheraton-Cadillac Hotel, Detroit, Oct. 9 and 10 for the Annual MSMS Scientific Meeting. They thronged scientific and technical exhibits (above), attended specialty meetings and were advised on economic, political and business affairs.

The annual MSMS Awards Luncheon drew nearly 200 persons who packed the hotel's Woodward Room for the presentation of Fifty-Year, National Presidents', Flag and Special MSMS Awards, as well as an address by AMA Executive Vice President-Designate James M. Sammons, MD.



Among the most popular of the special programs presented at the Scientific Meeting was the Thursday morning Practice Management Seminar, led by MSMS Economic Information Bureau Chief John Anthony, standing. Flanking Mr. Anthony were R. Timothy Hogan, left, and Donald Land, right, representatives of Professional Management-Black and Skaggs Associates, Inc., of Ann Arbor and Detroit, respectively.

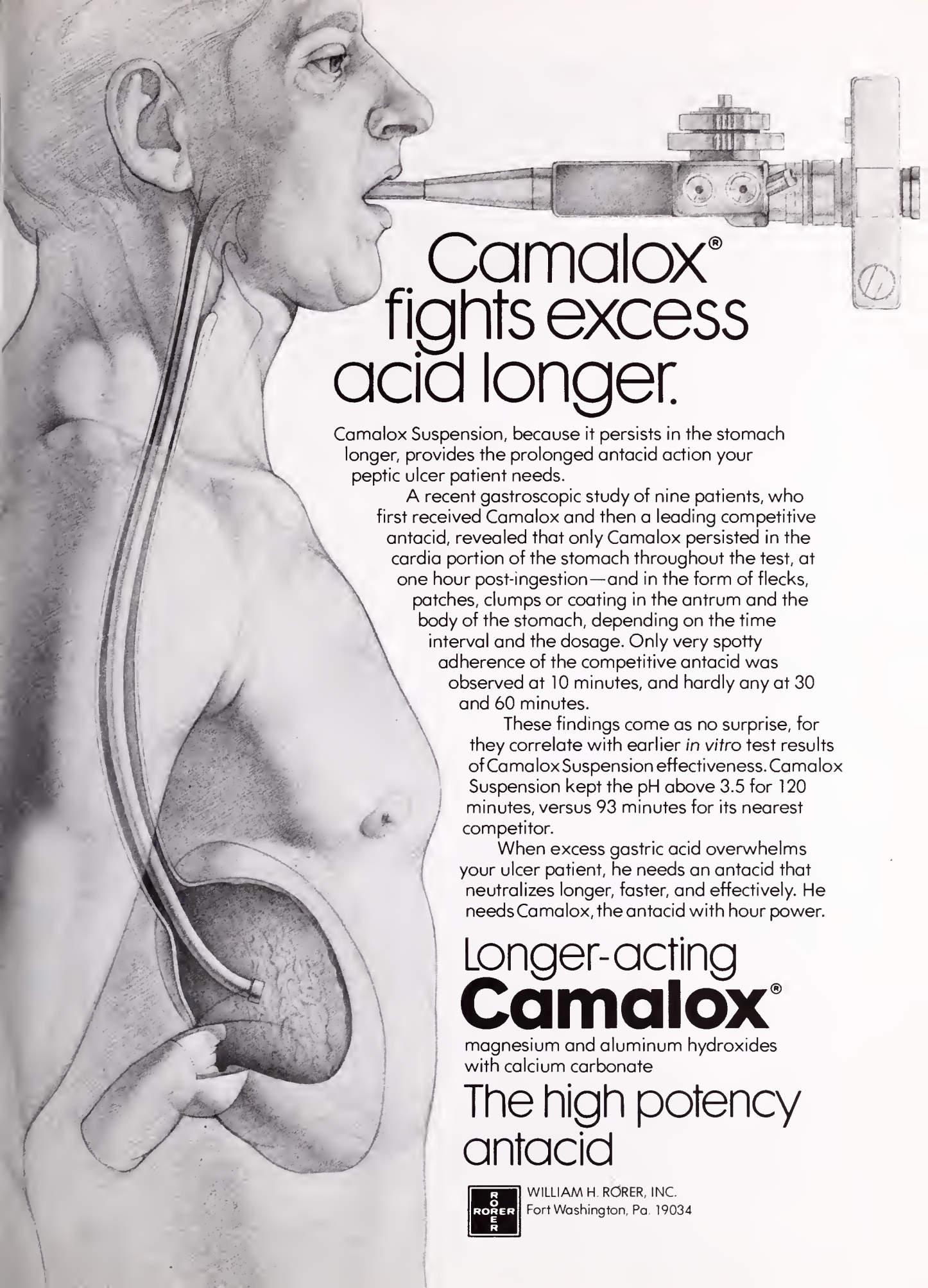
Among the dignitaries at the Awards Luncheon were from left, Doctor Sammons; MSMS President-Elect Brock Brush, MD, Detroit, and Harold Furlong, MD, Pontiac, who gave a graceful impromptu speech on behalf of the physicians honored on the 50th anniversary of their graduation from medical school.

A special award was made at the MSMS Scientific Meeting to H. Allan Barth, right, retiring executive vice president, Michigan Hospital Association, for his 27 years of service with MHA. Presenting the award was Brooker L. Masters, MD, MSMS president.

George W. Slagle, MD, Battle Creek, left, was among four Michigan physicians receiving awards as presidents of national medical organizations. Doctor Slagle, a former MSMS president, heads the Conference of Presidents and Other Officers of State Medical Associations. MSMS Council President Robert M. Leitch, MD, made the awards.

Other national presidents receiving awards were, from left, Leonard F. Bender, MD, Ann Arbor, American Academy of Physical Medicine and Rehabilitation; Joseph A. Rinaldo, Jr., MD, Southfield, American Society for Gastrointestinal Endoscopy, and Yvan J. Silva, MD, Detroit, American Association of Foreign Medical Graduates. Far right, Frank Aiuto, accepted a Flag Award (for presidents of statewide organizations) for his father, James J. Aiuto, MD, St. Clair Shores, of the Michigan Diabetes Association. Flag Awards also were earned by Donald G. Albert, MD, Royal Oak, Michigan Heart Association; Harold E. Bowman, MD, Grand Rapids, Michigan Division, American Cancer Society; Ezra V. Bridge, MD, Port Huron, Michigan Lung Association, and Roland R. Springgate, MD, Kalamazoo, Michigan Rheumatism Association.

Representatives of 10 news outlets (radio and TV stations, both Detroit newspapers and UPI) interviewed MDs and reported events at the Scientific Meeting. Barbara Threatt, MD, Ann Arbor, director, Michigan Breast Cancer Detection Center, was interviewed by WJBK-TV Newsman Jerry Hodak.



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Crib Death: Disease or Accident?

By Karl J. Kadlub, PhD and K. Gregory Kadlub, Battle Creek

The sudden infant death syndrome (SIDS) is an intriguing phenomenon if for no other reason than that it is a disease which does not make sense. It refers to deaths that have no reason for taking place. There are no prodromal symptoms — no premorbid signs; the very first symptom of this condition is death. Actually there is nothing about a crib death which would qualify it as a disease entity.

Nevertheless it has been speculated that various known diseases such as myasthenia gravis, deficiency in antibody formation, as well as the nature of sleep itself may be causative factors. In order to account for this most undisease-like of diseases, others have postulated a combination of symptoms, or neurological chain of events, which coincide to cause an "explosion." This, of course, explains the immediate transition from a state of health to a state of death without any intervening signs. Such an explanation, however, begs the question for it remains vague about actual causes.

The authors take a position that the principle cause of crib death is not a disease, but rather a mechanical obstruction of the central air passage by a large mass of air released from the stomach and trapped in the pharynx. And the child dies of *natural causes* (or accidental ones) much as a man might choke to death on a piece of steak lodged in his throat. We shall see that this proposition sets order to most of the facts and circumstances observed in relation to the infant death syndrome—as well as to the peculiar physiological and developmental characteristics of the infant through the first four months of life (during which such tragedies most commonly occur).

One of the most powerful arguments against a disease hypothesis is the fact that nobody has ever observed such a death taking place while the infant was held in its mother's arms (when the head is properly supported), while it was being played with and shifted in position, or in any of the myriad of situations that any family might spend in direct contact with a child. If SIDS were a disease which inevitably must kill, it would occur anyplace and anytime — as do epileptic seizures, the appearance of rashes, fevers or whatever.

Lying Horizontal Only Prerequisite

Lying in the horizontal position unattended seems to be the only documented prerequisite essential for this "disease" to manifest itself. It is noteworthy at this point to recognize that many adults experience difficulty or pain and at times find it impossible to belch while supine—and in order to relieve the discomfort one must rise to a sitting position, and even lean forward (so that the upper esophagus occupies a position above the main air passage at the juncture where both meet) in order to successfully raise that bubble of air. And such maneuvers are necessary in the mature of the species who are in possession of a completely developed gastrointestinal tract!

For many weeks after birth the child is a flaccid bundle of organs and lies in its crib like a rag doll assuming whatever contours exist beneath it; especially during deep sleep. Absence of tonus in the neck muscles and sagging or crimping in that area are doubtless accompanied by some distortion in the soft passageways used for intake of air and food. The alignment of a child's head and neck while sleeping is generally a far cry from the position that would allow optimum passage for these. For example, in the case of drowning or smothering one must raise the neck of a child, tilt the head way back and then keep the chin pressed upward throughout efforts at mouth-to-mouth artificial respiration. In many normal sleeping positions there is some degree of mechanical obstruction in the passageways of the neck; that point at which air and food first make entry, and where gas bubbles and vomit make their final exit. All of the evidence suggests this to be the prime site for "overloading" in the chain of events that results in crib death. This is where the stage is set for spasm or total collapse of the soft passageways in reaction to the driving force of gas expelled from the stomach.

Such phrases as "bubbling the baby" or "burping baby" are euphemisms. Though they apply to most bubbles of moderate size, new mothers are startled as well as amused when they discover their tiny infants to be capable of occasional discharges that match those of any adult. There is good reason for this. The infant's stomach will contain (relative to the child's size) proportionally far more than that of an adult; hence the obvious and comical bulging after a good feeding. It has been estimated that the infant will take in at one feeding an amount that is equivalent to two quarts in a 110 lb. adult. Infants also swallow incredible amounts of air during feeding, and considerable force may be generated behind the gas once it is expelled by the stomach. The stomach is a muscle, and much like a balloon is capable of driving out air explosively.

From the Battle Creek Sanitarium, Battle Creek and Veterans Administration Hospital, Fort Custer

Another factor to be considered in the chain of events that comprises the infant death syndrome is the relationship between that enormous capacity of the infant's distended stomach and the narrow esophageal passageway. This discrepancy in ratio (especially when compared to that of the adult) is staggering when one considers the demands placed upon that tube for rapid discharge of gas or any material. Generally the narrow esophagus will accommodate itself to such demands. The countless times that infants raise bubbles of air without incident, and the rarity with which this mechanism misfires with fatal consequences, are really testimony to the efficiency of the system despite the apparently ill proportioned aspects of the anatomy involved.

The final element to be considered is the fulminating or explosive-like impact of a large volume of gas upon that flexible esophageal tube, and what likely events take place in the area of the throat. It is unlikely that anyone will ever happen to be observing an infant under fluoroscope at the exact moment an SIDS takes place. The possibilities are numerous; whether the esophagus balloons out along its entire length and compresses or collapses the main airway at some point, whether there is a stricture or spasm in the area of the pharynx, or whatever. In any case, when the volume and pressure of gas released by the stomach achieve a certain threshhold the pliable passageways in the throat become overwhelmed. And it is likely that once discharged into the esophagus the main pocket of gas in the stomach continues to maintain pressure along the entire system. These are the necessary and sufficient physiological ingredients to account for the SIDS.

Victims May *Not* Die in Sleep

It is only *assumed* that victims of crib death die in their sleep. It is more likely that once the throat is paralyzed by a massive rush of gas from the stomach, the child is awakened by pain as well as the need for air, it struggles as best it can, and strangles silently; unable to draw in air because of its inability to expel the gas pressing against the juncture where both meet; and being unable to utter a sound because air cannot be moved in either direction over the vocal cords. Once lifeless, the throat and passageways relax releasing the trapped air and leaving no sign of the killer. Meanwhile the mother standing only yards away receives no warning or hint of the tragedy that has unfolded so near to her.

The normal action of the epiglottis is relatively simple with regard to the ordinary taking in of air and food. Its action is not so well understood at those times when it is caught between opposing forces; when it is called upon to mediate between such contradictory requirements as hiccupping, sneezing, breathing, coughing, eating and vomiting. "Doubling up" in this manner may be distressing and painful to adults even in a standing position. Though some such combination is even more difficult for an immature system to cope with, it probably plays an incidental role in crib deaths. It is only the belch which can generate sufficient physical force to immobilize or collapse the throat. The act of swallowing occurs hundreds of times during feeding, and continuing peristaltic movements which carry food and air into the stomach pouch may be likened to the pumping action of an air rifle which raises pressure to intense levels in gradual degrees. The gastrointestinal system was designed to move material in one direction — and it works that way most efficiently. There are occasions, though, when the stomach will "backfire" and drive gas with intense force opposite to the normal direction of action in this system or "against the grain." Only an experience of this type and magnitude would be capable of jamming the machinery with lethal consequences.

One hypothesis on the exact mechanism of crib death is worthy of mention; i.e. a likely manner in which infants might *strangle themselves from within* on the basis of ordinary anatomical structure and physiological function. The back of the nasal cavity angles rather sharply to merge with the esophagus; and so forms an elbow or "blind alley." Secondly, it is a curious fact that during those months when infants are most susceptible to crib death they are "nasal breathers." For some unknown reason they will not open their mouths to breathe even if they are suffering considerable distress due to clogged nasal passages. Thus the middle and lower pharynx actually form a culde-sac of sorts when material is moved in a direction from the stomach to the mouth. Whenever the stomach releases a discharge of gas, it runs the entire length of the esophagus and resistance is encountered for the first time in the throat. (Even in the adult the belch typically requires two distinct stages for completion: the gas is initially caught up in the throat, there is a momentary pause following which it is then released through the mouth and/or nose.) It is postulated that the sudden death syndrome is triggered when an unusually intense discharge of gas is halted abruptly in the throat and the pliant membranes of the immature pharynx are suddenly and inordinately expanded under the pressure . . . *and this triggers the swallowing reflex.* The reflex discharge of motor nerves closes off the nasal, oral and laryngeal cavities, and inhibits respiration while pushing the "contents" of the throat back into the gullet. With pressure being maintained along the entire length of the esophagus by the unexpelled reservoir of gas still in the stomach, and the swallowing reflex being simultaneously and repeatedly triggered (which prevents relaxation of the throat and its cavities), both ends of the system work against the middle!

In the infant the epiglottis is a "soft and floppy" bit of tissue, and it is likely that when this area is engorged with trapped air such a soft bit of skin is literally sealed over the main airway. The infant is then unable to generate enough power with its diaphragm to override the greater opposing pressure of gas maintained by the stomach, and incapable of drawing any air into its lungs.

The literature testifies to the regularity with which pediatricians had pronounced SIDS victims to be in perfect health at the time of birth, and parents who described them as subsequently thriving, responsive and with "sunny" dispositions. Contrary to popular opinion, crib deaths probably take the healthier of our young. Those infants with greatest appetite, who suck with greatest intensity and greed, will swallow the most air and be capable of the lustiest belches. It is not by accident that many medical examiners and coroners continue to label the cause of death in cases of SIDS to be "suffocation." There is no other technical way to account for it — no other medical description which applies so well for purposes of the death certificate. All of the cardinal signs on autopsy support such a conclusion; congestion of the lungs and edema, hemorrhages on the pleural surfaces, bloody mucous in the nose and mouth, and slight respiratory tract inflammation. The classic explanation for crib death, suffocation, is still the most parsimonious.

The Timing of SIDS

It has been observed that SIDS never strikes during the first two weeks of life, and that such deaths most commonly take place between one and four months. What do we know about the habits and development of infants during these early critical months? We know that the average child doubles his birth weight at about five months. During those months when the gastrointestinal tract is most immature it is called upon to accomplish perhaps its greatest feat. These months are known to be "rough" on many infants who suffer from various degrees of colic and periods of "irritable crying." Both of these conditions begin at about two weeks of age and may continue until four or five months.

It is likely that infants are protected from SIDS during the first two weeks of life simply because they cannot get enough into their stomachs to do any real damage. There are probably many good reasons why the mother's milk supply is not established until days after childbirth. The infant's stomach does not become completely functional along with the lungs after one slap on the backside, and it is not ready for a full meal. Frequent feedings are required during the early days as the immature digestive system slowly adjusts to the new experience.

Another possible factor contributing to SIDS is the fact that babies gradually lengthen the intervals between feeding as they grow older. Most infants give up night feeding by one to two months of age, and many are feeding at five hour intervals by three to six months. The point is that with increasing intervals between feedings, the need for food and urgency with which the child goes after it are intensified. Dr. Benjamin Spock beautifully describes the intensity with which the healthy child feeds:

> * "He is so eager when the nipple goes into his mouth that he almost shudders. When he nurses, you can see that it is an intense experience. Perhaps he breaks into perspiration. If you stop him in the middle of a nursing, he may cry furiously . . . This all adds up to the fact that feeding is his great joy."

In the earliest days infants often need food every three hours; they require feeding eight times during a 24 hour period. Is it coincidence that crib deaths make their first appearance at about two weeks of age when so many young make a transition to six feedings? And during subsequent months as infants settle down to even fewer feedings the incidence of SIDS rises. The greater the interval of time between feedings, the more ravenous the child will be and the more air he will swallow as he gorges himself.

That interval of time in the infant's life when the greatest incidence of crib deaths occur corresponds exactly to that period during which he has his greatest sucking need. Many babies are able to get their thumbs and fists into their mouths by the second and third months of life, and there is no voluntary control over this activity. How much air does an infant swallow between feedings? It has been observed that some babies become uncomfortable midway through a feeding and must stop; others never swallow enough air to override the hunger and sucking instinct or to interrupt it.

Other Factors

Let us now consider other factors which come into play during those months that the incidence of SIDS begins to taper off. The average baby begins teething at about the age of four months, and he continues teething most of the time for the next two years. At four months many infants become fretful, their sensitive gums cause distress, they lose appetite and this keeps them under some degree of rein; they are slowed down for the first time at that point where food is taken in. Perhaps more important is the fact that at about eight months (a time beyond which SIDS rarely strikes) is when most infants reach a stage in muscular coordination and development that they can learn to sit

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* The Common Sense Book of Baby and Child Care; Benjamin Spock; Duell, Sloan & Pearce

steadily after being helped up. This, of course, also signals the time that most young can support their frames more adequately regardless of position, and be capable of maintaining far better alignment of the passages in the throat.

The sudden infant death syndrome claims more boy babies than girl babies. One might hypothesize that the higher basal metabolic rate of boys renders them hungrier and consequently more voracious than girls. A likelier reason, however, is that pyloric stenosis is more common in boy babies. This is a condition in which the valve at the far end of the stomach will not open normally and allow food to pass through into the intestines. As a consequence food is periodically vomitted out with great force and often lands at considerable distance from the baby's mouth. Projectile vomitting also occurs occasionally in children who do not have such a condition. Anybody who has witnessed projectile vomitting can appreciate the explosive force that may be generated by the stomach. This uncommon form of vomitting also begins when the baby is two to three weeks old; that point in time when crib deaths first appear. The vomitting reflex, however, throws the trunk, neck and head into play in such a way that is conducive to proper alignment for expelling food. This is just not the case when gas is released! It often needs help along the way. Intense belches are all "projectile" in nature, but have no accompanying postural changes to accommodate them.

SIDS also takes more infants whose birth weight is below average; another factor which is related to the degree of hunger experienced by a child, and the extra urgency with which it will suck. Sudden infant deaths also occur most commonly during the cool months. Still another factor related to feeding. After a hot and humid season during which the appetite has been cut and weight lost, does not the child's appetite rebound dramatically during a cool spell?

Finally, it has been observed that a second occurrence of SIDS in the same family is unlikely. This merely underscores the proposition that such a death is a matter of chance or accident. SIDS is just as likely in a family that has suffered one previously as with any other family (three out of every 1,000) which is not very unlikely. More accurately, the probability is very low that a highly improbable event will strike the same family twice.

The very mechanism of the sudden infant death syndrome then accounts for its elusive nature, the mystery in which it has been shrouded over the centuries, and search after some exotic disease in order to explain it. The chain of events culminating in such deaths occurs so rapidly, it is so "natural," and leaves no trace behind. Such a *cause* of death will be difficult if not impossible to observe, demonstrate or verify scientifically.

How to Avoid SIDS?

In light of the above, what can one advise the new mother? To make certain they burp their young after every feeding, to take an extra ten or fifteen minutes in a rocking chair with the child held upright and head resting against the shoulder, to avoid whenever possible delaying feedings so that the infant is not beside itself with hunger, and not to be too hasty in increasing intervals of time between feedings. During the first four to six months of life the child should be fed on demand. The infant alone knows *when* it needs to be fed as well as how much it requires at every feeding. One also may wonder whether the incidence of SIDS is not higher in the bottle fed baby than in the breast fed infant.

But even with precautions such as these it is likely that only *some* of the crib deaths may be circumvented; for the peculiar anatomical structure of the infant's upper gastrointestinal and respiratory systems, as well as the dynamics involved, render any healthy child susceptible to it even under the most ideal conditions.

Validation of the position taken in this paper may be possible in one way; demonstration of a significant decline in the incidence of crib deaths *after* all new mothers in some city or county follow the precautions mentioned above for a full year. It would be essential, however, that the region selected have decent statistics on such deaths from previous years for purposes of comparison.

Active organizations who have heretofore involved themselves only with comforting the parents of such victims could contact all new mothers, provide pamphlets and otherwise instruct them on the precautions mentioned above — but with emphasis on *not creating or intensifying neurotic anxieties* in the process. Then all that would be required would be a period of waiting. In any case, the authors felt there was no good reason for withholding the information in this paper from the population at large.

Severe Hypotension Following Intravenous Propranolol In a Hyperthyroid Patient

By Hassan Amjad, MB, BS; Renato G. Ramos, MD and James Gels, MD, Royal Oak

Propranolol hydrochloride is widely used in the treatment of various arrhythmias.[1] Adverse side effects are infrequent, mild and reversible; however, hypotension, cardiovascular collapse and death can occur in those with underlying cardiopulmonary disease.[2,5] We would like to report the occurrence of profound hypotension following intravenous administration of propranolol hydrochloride (Inderal) in a patient with hyperthyroidism but no clinical cardiac disease.

Case History: A 48 year old Negro man presented in the emergency room of William Beaumont Hospital in November 1973 with symptoms of rapid heart beat. The patient had had several episodes of palpitations in the past terminated spontaneously by a Valsalva type maneuver by the patient. Five months prior to the emergency room visit an episode of paroxysmal atrial tachycardia was recorded electrocardiographically, and the patient was started on digoxin 0.25 milligrams orally daily. The patient, however, stopped taking the medication after a month because the frequency of palpitations did not decrease. The past history was otherwise negative.

Physical Examination: Blood pressure 130/70 right arm recumbent. Neck veins were flat. There was no palpable cardiomegaly. Heart sounds were regular with no extra sounds or murmurs. Rate over 190 per minute. Lungs were clear. Liver was not palpable. No ankle edema. The electrocardiograms showed supraventricular tachycardia in excess of 190 per minute with complete right bundle branch block *(Figure 1)*.

Carotid sinus massage was done with no affect. Tensilon 10 milligrams IV was then given followed by transient periods of conversion to normal sinus rhythm.

About twenty minutes later 0.5 milligram of Inderal was administered intravenously followed 15 minutes later by one milligram, also intravenously. Within 10 minutes after the last dose, the patient became extremely restless, pale and diaphoretic. Blood pressure was unobtainable by sphygmomanometry. The rhythm remained the same. An intravenous levarterenol bitartrate (Levophed) drip was started and digitalis 0.5 milligrams given intravenously. As systolic pressure went up to 150 mm HG the tachycardia suddenly converted to normal sinus rhythm *(Figure 2)*. The subsequent clinical course was unremarkable.

The results of laboratory studies are as follows: Hemoglobin 14.4 grams, hematocrit 43, serum glutamic oxalo-acetic transaminase 65 units (normal less than 40), lactic dehydrogenase 225 units (normal less than 200), creatinine phosphokinase 4 (normal less than 12). Serum electrolytes were normal. Chest x-ray showed no cardiomegaly or pulmonary congestion.

The following tests for thyroid function were elevated: serum thyroxine (T4) 16 (normal less than 12), free thyroxine index (FTI) 1.9 (normal less than 1.2). The patient was discharged for outpatient treatment. Unfortunately, he never returned.

Discussion: Tachycardia is a normal response to congestive heart failure. This results primarily from an increase in adrenergic tone necessary for the maintenance of cardiovascular integrity. Persistent tachycardia, however, further compromises cardiac function by decreasing diastolic filling, hence cardiac output. By removing the chronotropic effect of endogenous catecholamines, propranolol is the drug of choice in catecholamine-induced arrhythmias. This is the basis for its usefulness in PAT in associated hyperthyroidism. In patients with incipient heart failure, lysis of the adrenergic tone coupled with the negative inotropic action of propranolol can lead to overt congestive failure hypotension. The occurrence of severe hypotensive episode following intravenous administration of 1.5 milligrams of propranolol in our patient in the absence of clinical heart disease is, however, unexpected. It is possible that the high level of sympathetic activity is equally important in these patients and sudden reduction of same may result in severe hypotension. The direct cardiac effects of thyroid hormone is little understood and cannot be implicated at this time.

From William Beaumont Hospital – Royal Oak, Michigan

Address for reprints: Hassan Amjad, MB, BS, William Beaumont Hospital, 3601 West Thirteen Mile Road, Royal Oak, 48072.

A hypotensive reaction to propranolol should be treated aggressively with isoproterenol and/or Glucagon. The dose of isoproterenol should be biologically titrated since there may be excessive beta-blockade.

Summary

A severe hypotensive response to intravenous propranolol in a hyperthyroid patient with no underlying clinical heart disease is reported. Sudden lysis of increased sympathetic activity is implicated and caution should be exercised when using this drug in patients with clinical heart disease and hyperthyroidism.

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1. Lawrence, T; Frankl, WS: Beta Adrenergic Receptor Blocking Drugs. *Med Clin North America* **57**:985-999, 1973.

2. Scobbo, RR; Chung, EK: Unusual Reaction to Propranolol. *W Virginia Med Journal* **68**:190-192, 1972.

3. Stephen, SA: Unwanted Effects of Propranolol. *Am Journal Cardiology* **18**:463-472, 1966.

4. Clinical Anesthesia Conference: Severe Hypotension Following Administration of Propranolol Hydrochloride. *N Y State Journal of Med* **73**:2702-2703, 1973.

5. Viljoen, JF; Estafanons FG; Kellner, GA: Propranolol and Cardiac Surgery. *J Thorac Card Surg* **64**:826-830, 1972.

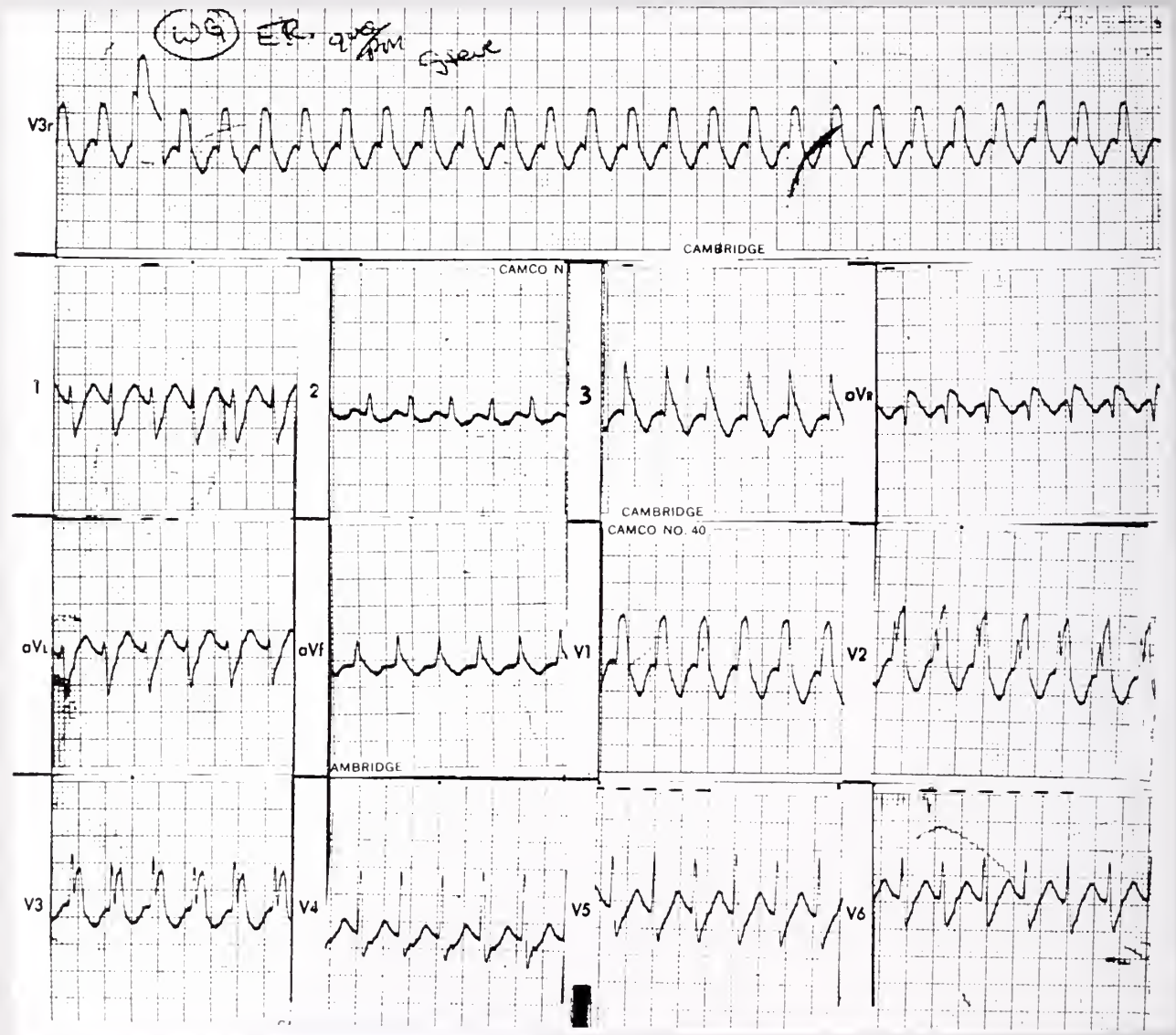

Figure 1

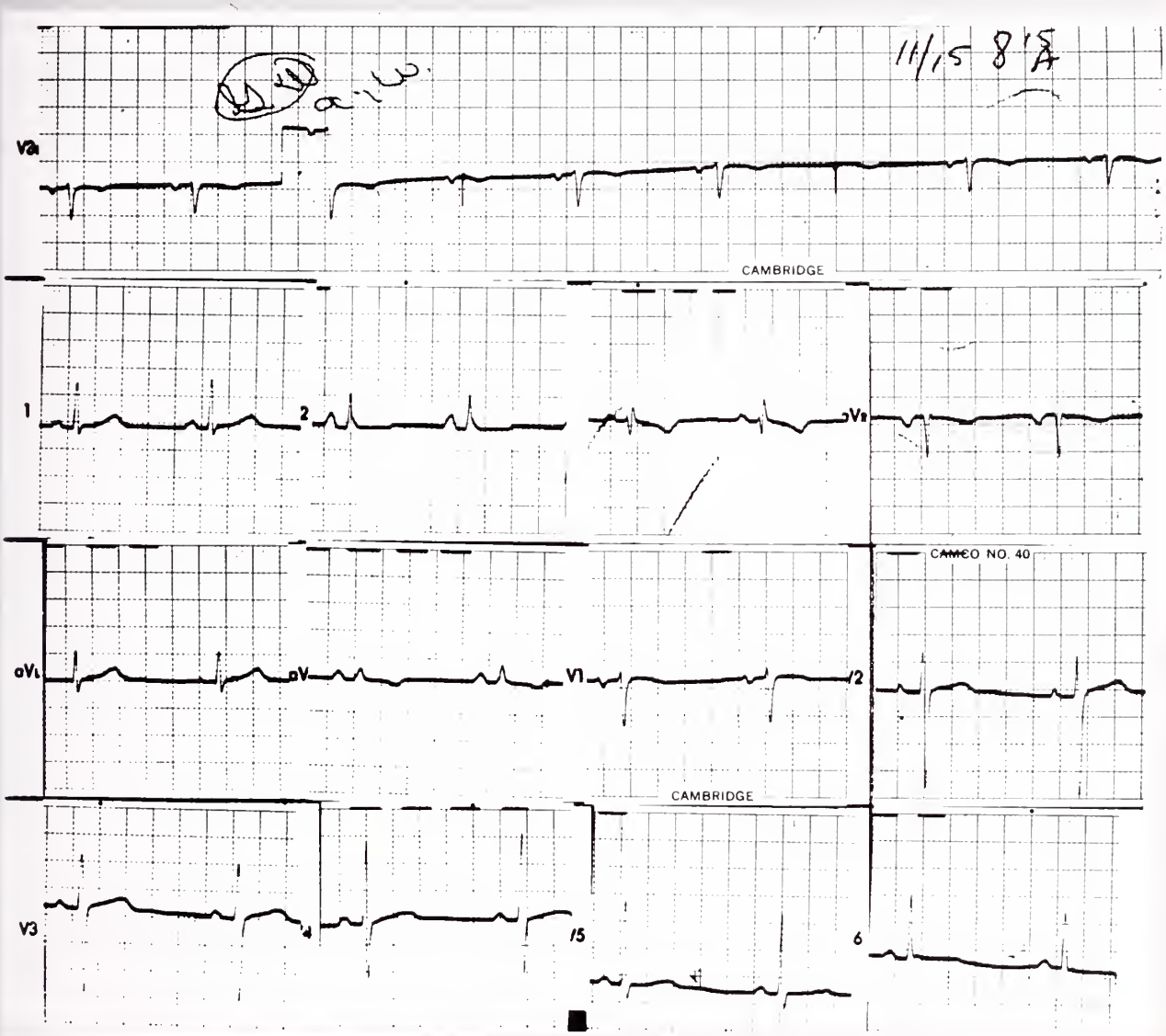
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Figure 2

MEETINGS

Nov. 15–Ninth annual Professional Symposium for Michigan physicians, sponsored by Professional Education Committee of Kent County Heart Unit, Michigan Heart Association, Hospitality Inn, Grand Rapids, contact: Mohammad Riahi, MD, 21 Michigan St. SE, Grand Rapids 49502.

Nov. 15-16–Postgraduate anesthesiology conference, U-M Medical Center, Ann Arbor.*

Nov. 16-17–First National Conference on Methods of Venereal Disease Prevention, Center for Continuing Education, University of Chicago, sponsored by Midwest Association for the Study of Human Sexuality, contact: Jerry Lama, Midwest Association for the Study of Human Sexuality, 100 East Ohio St., Chicago 60611.

Nov. 20—Fourth Annual "physicians for Michigan Communities Health Fair," at MSU, sponsored by MSMS, Michigan Health Council, the three medical schools, Michigan Blue Cross-Blue Shield, contact: John A. Doherty, Executive vice president, Michigan Health Council, 712 Abbott, East Lansing 48823.

Nov. 25-26—Human Sexuality Workshops for health professionals, U-M Medical Center, Ann Arbor.

Nov. 30-Dec. 4–AMA Clinical Convention, Portland, Ore., contact: Convention Coordinator, AMA, 535 N. Dearborn St., Chicago 60610.

Dec. 4–Postgraduate course in cardiology for family physicians, U-M Medical Center, Ann Arbor.*

Dec. 5–PAS and MAP Institute sponsored by Commission on Professional and Hospital Activities, at Ann Arbor, contact: CHPA, 1968 Green Road, Ann Arbor 48105.

Dec. 6-7–Twenty-second annual Trauma Day, sponsored by Wayne State University Department of Surgery and Michigan Committee on Trauma of the American College of Surgeons, at Harper Hospital, contact: Lynn E. Ernest, coordinator, WSU Department of Surgery, Scott Hall, 540 E. Canfield, Detroit 48201.

Dec. 11–MSMS Council, MSMS Headquarters, contact: Warren F. Tryloff, director.

Jan. 10-11–Respiratory therapy conference, U-M Medical Center, Ann Arbor.*

Jan. 20-24–Family Practice Review, U-M Medical Center, Ann Arbor.*

Feb. 3-7–American College of Physicians postgraduate course on current concepts in oncology, cosponsored by U-M Medical Center, at Towsley Center, Ann Arbor, contact: ACP, 4200 Pine St., Philadelphia 19104.

Feb. 18-20–Postgraduate course in EKG diagnosis, U-M Medical Center, Ann Arbor.*

Feb. 20-22–Otorhinolaryngology conference, U-M Medical Center, Ann Arbor.*

Feb. 25-28–Postgraduate course in emergency medicine, U-M Medical Center, Ann Arbor.*

March 5-6–Postgraduate course in advances in pediatrics, U-M Medical Center, Ann Arbor.*

March 10-11–Postgraduate course on surgical complications, prevention and management, U-M Medical Center, Ann Arbor.

March 18-20–Postgraduate course in morphology of the blood and marrow, U-M Medical Center, Ann Arbor.*

March 31-April 2–OB-GYN conference, U-M Medical Center, Ann Arbor.*

April 16–Postgraduate course on orthopedics in family practice, U-M Medical Center, Ann Arbor.*

April 17-18–Course on medical technology/hematology, U-M Medical Center, Ann Arbor.*

April 21-25–American College of Physicians postgraduate course on recent progress in clinical endocrinology, co-sponsored by U-M Medical Center, at Towsley Center, Ann Arbor, contact: ACP, 4200 Pine St., Philadelphia 19104.

April 24-25–International conference on andrology, "The Human Semen and Fertility Regulation in the Male," at Wayne State University School of Medicine, contact: E. S. E. Hafez, PhD, WSU School of Medicine, 550 E. Canfield, Detroit 48201.

April 24-26–Meeting of the Midwestern Association of Plastic Surgeons, Shiawassee Hotel, Southfield, contact: Burns Newby, MD, 20905 Greenfield, Southfield 48075.

May 1-2—Ophthalmology conference, U-M Medical Center, Ann Arbor.*

May 13-14–Postgraduate course in therapeutics, U-M Medical Center, Ann Arbor.*

June 3-6–Postgraduate course in "Advances in Internal Medicine," U-M Medical Center, Ann Arbor.*

June 15-19–AMA Annual Convention, Atlantic City.

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*Contact Robert K. Richards, Towsley Center, University of Michigan, Ann Arbor 48104.

Post-Craniotomy Staphylococcal Infections Following Drainage with the Hemovac System

By Francis M. Wilson, MD, Michael J. Federman, MD Harvey H. Gass, MD, and A. Martin Lerner, MD, Detroit

Abstract

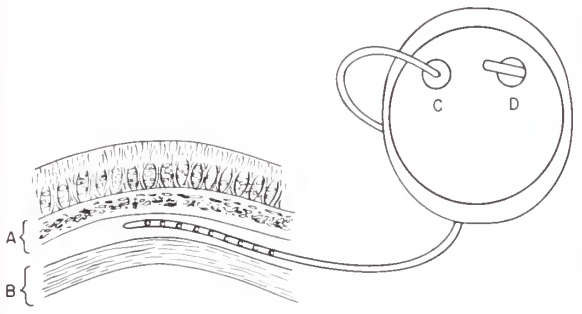
Use of the Snyder Hemovac drainage system was instituted by a single neurosurgeon at Sinai Hospital of Detroit for a three month period in the summer of 1967 in all patients requiring craniotomy and insertion of a bone flap. Among eight patients whose courses could be analyzed, six nosocomial *Staphylococcus aureus* wound infections occurred. The incidence was much higher than the expected incidence of six percent. Two additional patients with similar wound infections were also studied. Vigorous early intravenous antistaphylococcal treatment for a course of four weeks prevented chronic osteomyelitis of the bone flap in four of the cases.

The Snyder Hemovac drainage system* consists of a drainage tube connected to a self-contained suction bag. This draining apparatus has been used in various surgical procedures including dissections of the neck, breast and groin. The manufacturers recommend Hemovac drainage after other operations upon the thorax, abdomen, or urinary system. In each instance removal of serous effluent from a wound relieves pressure upon surgical incisions.

In an attempt by one of us (HHG) to facilitate drainage from the extradural space in the initial post-operative period, the Hemovac system was used following 12 craniotomies. Suction tubes were inserted in the space between the cranial bone and the dura mater in the operating room and removed 24 hours later *(Figure 1)*. The Hemovac performed well, but a marked increase in staphylococcal wound infections, some severe and chronic, occurred. This report describes this unusual experience.

Methods

From June through September, 1967, the Hemovac was used after 12 consecutive craniotomies which required use of a bone flap. On account of complicating factors which interfere with evaluation of the role of the Hemovac, four of the 12 patients were eliminated from this analysis. Reasons were: use of antibiotics immediately after surgery in two patients, cerebrospinal fluid rhinorrhea post-operatively in another patient, and a pre-operative subgaleal space infection in the final patient. Two patients also noted to have wound infections following this type of operation without the use of Hemovac were also analyzed. These infections occurred in a two month period before the Hemovacs were used.



(A) Cranial Bone. (B) Dura Mater. (C) Effluent drainage from extradural space enters Hemovac under negative pressure. (D) Drainage is emptied by opening bag.

* Snyder Hemovac (Pat. No. 3115138), distributed by Zimmer, Warsaw, Indiana.

Doctor Wilson is associate director of medical education, Hutzel Hospital Medical Unit, and associate professor of medicine, Wayne State University School of Medicine. Doctor Federman is chief, Section of Infectious Diseases, Sinai Hospital of Detroit, and clinical instructor in medicine, WSU School of Medicine. Doctor Gass is chief, Section of Neurosurgery, Sinai Hospital of Detroit and adjunct professor of neurosurgery, WSU School of Medicine, while Doctor Lerner is chief, Hutzel Hospital Medical Unit, chief, Division of Infectious Diseases and professor of medicine, WSU School of Medicine.

The authors were aided by PHS Training Grant (AI 00261) from the National Institute of Allergy and Infectious Diseases and a grant from the Skillman Foundation for general support of Infectious Diseases at Wayne State University.

Reprints should be addressed to Doctor Lerner at Hutzel Hospital, 432 E. Hancock, Detroit, 48201.

Table I

Post-Craniotomy Wound Infection Among Patients Requiring Use of a Bone Flap From May, 1967 — September, 1967 at Sinai Hospital of Detroit

Patient No.	Hemovac	Age	Sex	Date of Cranio-tomy	Wound Infection Noted	Culture of Wound	Sensitive to Penicillin	Antibacterial Treatment		Recurrence	Other
								Daily Dosage	Duration (Days)		
1	No	65	F	5-4-67	8 days later	*S. aureus*	Yes	tetracycline 2 gm/PO	7days	Yes	Osteomyelitis of bone flap at removal (7-20-67)
2	No	53	M	5-9-67	10 days later	*S. aureus*	No	none	—	Yes	Chronic drainage (12-20-67) osteomyelitis of the bone flap suspected
3	Yes	56	M	6-20-67	4 days later	*S. aureus* *Klebsiella*	Yes	ampicillin 2gm/PO	10 days	Yes	Chronic drainage; reoperation (3-1-70)
4	Yes	38	M	6-23-67	less than one day	*S. aureus*	Yes	tetracycline 2 gm/PO	3days	Yes	Drainage 7-24-67; Treated 60 million units penicillin G for 4 weeks. Bone flap removed 10-30-67 (osteomyelitis)
5	Yes	52	M	7-10-67	11 days later	*S. aureus*	No	cephalothin 2 gm/IM methicillin 9 gm/IV probenecid 1 gm/PO	8 days 21 days 21 days	No	
6	Yes	33	F	7-13-67	7 days later	Sterile		cephalothin 2 gm/IM, 9 gm/IV probenecid 1 gm/PO	8 days 28 days 28 days	NO	
7	Yes	51	F	9-15-67	8 days later	*S. aureus*	No	cephalothin 9 gm/IV probenecid 1 gm/PO	35 days 35 days	No	
8	Yes	37	M	8-18-67	6 days later	*S. aureus*	No	cephalothin 9 gm/IV probenecid 1 gm/PO	28 days 28 days	No	

Results

The occurrence of post-operative wound infections following craniotomies in eight patients was studied. Operations in the Hemovac group were done between June 20, 1967 and September 15, 1967. All operations were done by one of us (HHG) at Sinai Hospital of Detroit.

There were six cranial wound infections after eight operations (75%) in the Hemovac group. Similar wound infections would be anticipated at a rate of about 6% and are compatible with infection rates reported elsewhere.[1] This had previously been determined by one of us (HHG) in his craniotomy experience prior to this series of cases in the same operating suite.

Coagulase positive strains of *Staphylococcus aureus* were recovered from seven of the infected wounds *(Table 1)*. Drainage from one of the wounds was sterile (patient 6, *Table 1),* but the patient was receiving cephalothin prior to obtaining this specimen. Of the seven staphylococcal isolates, three were sensitive to penicillin G by Kirby-Bauer technique. Case number 3 had a mixed staphylococcus-klebsiella infection.

Infections of craniotomy wounds were noted from the first through the 11th post-operative day. Every infected patient was febrile. Of the eight postoperative wound infections studied, four became chronic *(Table 1*, patients 1, 2, 3, 4). Three required reoperation *(Table 1,* patients 1, 3, 4). All were suspected to have chronic osteomyelitis of the avascular bone flap, and both bone plates which were removed confirmed this impression *(Table 1,* patients 1, 4). When infections were quickly recognized, etiologic diagnosis by culture made before initiating therapy, and vigorous anti-staphylococcal treatment with cephalothin or methicillin (9 gm/24 hr) maintained for about four weeks, results were excellent *(Table 1,* patients 5, 6, 7, 8). When lesser medical regimens were used, results were uniformly poor.

Discussion

Wright reports the incidence of post-operative craniotomy infections to be about 6%.[1] When nosocomial infections of every type were surveyed at the Boston City Hospital on medical and surgical wards in 1964, the overall incidence was 13.5% and *Staphylococcus aureus* accounted for 34% of them.[2] Numbers of patients reported here are small, but there is a striking increase in infections after Hemovac drainage was instituted; 75% compared to the expected rate of 6%. Control and infected patients were similar in age and type and duration of operation. A single operator performed throughout. Both penicillin G sensitive (three patients) and resistant strains of *Staphylcoccus aureus* (four patients) were implicated, so that a single human carrier of these staphylococci is not likely. The surgeon, his nurses, and operative assistants had no furuncles. Nose and throat cultures done on these personnel were negative. Infections abruptly stopped when one of us (AML) suggested that the Hemovac foreign body might be related to the troublesome increase in nosocomial infections.

The Hemovac drainage system introduces another foreign body to a dead bone flap in a poorly vascularized extradural space. Since the suction bag is repeatedly opened for emptying *(Figure 1, D)*, retrograde contamination of staphylococci (or other bacteria) from the hands of attending personnel is possible. It is important that a similar increase in post-operative infections has not been observed when the Hemovac system has been used at other sites. No other operation, using this system, however, leaves a rigid structure such as avascularized bone flap in situ which prevents obliteration of dead space by apposition of soft tissue layers. In another institution three percent of coagulase-positive staphylococci were resistant to methicillin.[3] We are fortunate that none of the infections were due to methicillin-resistant staphylococci.[4]

Post-operative neurosurgical infections may have severe morbidity and high mortality.[1,5,6] We experienced severe morbidity with four of the eight patients having chronic draining wounds of the scalp with probable osteomyelitis of the avascularized bone flap.[7] No death was directly related to these infections.

Osteomyelitis of a bone flap following wound infection of the scalp has been noted by others.[1,6] Never, however, has an incidence such as ours been reported.

Bacteriostatic antibiotics *(Table 1),* tetracycline (patients 1,4), or suboptimal use of ampicillin (patient 3) for short periods may suppress drainage temporarily. Relapse may occur, and a chronic infection is established. In evaluating the febrile post-operative neurosurgical patient, the wound must be inspected. Cultures of the wound must be obtained before starting antibiotics. Gram negative bacilli as well as staphylococci may be found.[5]

Vigorous parenteral and prolonged antibacterial treatment early after the onset of infection of the wound is indicated. The presumptive early diagnosis must include possible osteomyelitis of the bone flap. We treated four patients promptly and vigorously for one month with methicillin or cephalothin 9 gm/24 hours. None of these patients *(Table 1*, patients 5-8) had a recurrence.

Among other foreign materials, use of intravenous plastic catheters,[8] indwelling Foley catheters,[9] tracheostomies,[10] prosthetic cardiac valves,[11] Ommaya cerebrospinal fluid reser-

voirs,[12] and ventriculopleural or ventriculocisternal shunts[13] have been associated with an increased occurrence of nosocomial infections. We now add the Hemovac drainage system in craniotomy patients who require a bone flap.

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MICHIGAN DEPARTMENT OF PUBLIC HEALTH

Monthly Surveillance Report

Cases of Certain Diseases
Reported to the Michigan Department of Public Health
For the Four-Week Period Ending August 30, 1974

	1974 This 4-Week Period	1973 Same 4-Week Period	1974 Total To Above Date	1973 Total Same Date	Total Cases for 1973
Rubella	29	42	1,176	1,823	2,001
Cong. Rubella Syndrome	0	0	0	1	4
Measles	18	51	1,904	4,353	4,552
Whooping Cough	10	3	61	47	86
Diphtheria	0	0	0	0	0
Mumps	73	39	5,381	3,893	5,042
Scarlet Fever & Strep Sore Throat	621	920	25,685	15,285	24,467
Tetanus	2	0	3	1	2
Poliomyelitis (paralytic)	0	0	1	0	0
Hepatitis	235	324	2,487	2,606	3,872
Salmonellosis (other than S. typhi)	74	85	699	462	795
Typhoid Fever (S. typhi)	0	2	6	8	14
Shigellosis	220	58	894	407	623
Aseptic Meningitis	24	115	87	233	434
Encephalitis	9	17	43	115	163
Meningococcic Meningitis	1	3	35	39	54
H. Influenza Meningitis	3	0	83	70	89
Tuberculosis	122	121	951	1,081	1,380
Syphilis	155	263	1,896	2,922	4,328
Gonorrhea	2,665	2,726	20,935	19,747	31,128

Information can be supplied by the local health department on the local incidence of disease.

Michigan Pediatricians Ponder Care of Congenitally Defective and Handicapped

By Susan Berman
Special to Michigan Medicine

The Michigan Chapter of the American Academy of Pediatrics (MCAAP) recently invited its members to comment on the ethical problems posed by care of congenitally defective or severely handicapped newborn. As the discussion is of high interest to most Michigan physicians, it is summarized here.

* * *

The MCAAP cited a case which took place in a Detroit hospital. Observations were offered by Wolf W. Zuelzer, MD, professor of pediatric research, Wayne State University and director, Children's Research Center of Michigan. Doctor Zuelzer asked many thought-provoking questions, but offered no pat answers.

"Let us affirm as human beings, as citizens and as physicians," he said, "the belief that the mentally retarded, the malformed and the genetically defective children who are viable or can be given a tolerable existence have indeed the right to life. A civilized society can and must bear this burden.

"But we need not unthinkingly increase it by the indiscriminate use of life-saving devices. At the very least we should ask our fellow citizens to re-examine with us the limits of our duty. Is the preservation of life still our unconditional obligation?"

Responding physicians had no easy solutions; the only point of general agreement was the necessity of open discussion on moral decisions involved in newborn care.

The specific case cited in the MCAAP mailing involved a newborn, obviously mongoloid, with a duodenal atresia. The parents, both MDs, and the attending physician decided not to permit corrective surgery. When an anonymous informant gave the story to a newspaper, juvenile court became involved and judged the case as potential child neglect. Faced with the prospect of losing custody of the child so that a court appointed guardian could authorize surgery, the parents chose to request an operation themselves.

Discussion Begins

Homer F. Weir, MD, superintendent, Southgate Residential Training Center, challenged the original decision of the parents.

First, said Doctor Weir, the premise that the parents, as doctors of medicine, were uniquely qualified to make a life and death decision concerning their mongoloid child was false.

Secondly, Doctor Weir maintained that, today, surgical repair of duodenal atresia is not an extraordinary measure. Doctor Weir questioned the assumption he saw in Doctor Zuelzer's comments that physicians have a "right" to make such decisions. "My pediatric mentors taught me . . . to follow the precepts of the Hippocratic Oath. I can find no mandate for the physician to exercise his 'right' to make decisions over life and death."

Yet, there is another view, that such crucial decisions frequently are made and perhaps the physician and the parents are the best equipped to make them. James L. Wilson, MD, Ann Arbor wrote "It seems to me that a young man with a medical education and proper training, having passed his board requirements and with a license to practice medicine as a pediatrician should be allowed with his intimate knowledge of the whole situation to make his own decisions without direction from the Academy or from a court."

At least one physician felt most parents are able to adapt to the fact that their child is not normal. James W. Ledrick, MD, Grand Rapids wrote, "The parents of normal children are concerned about whether their children are going to succeed scholastically or whether they are going to be hit by a car on the way to school. The parents of a handicapped child do not concern themselves so much with the A's or B's, but with whether a child will talk or not . . . Although the goals may be less for a deformed child, are they any less real when they have been accomplished, and is the joy any less to those parents? I think not."

Are there other segments of society which should be involved in such decisions? J.H. Redin, MD, of Flint's Children's Center stated, "Obviously, we physicians are beyond the limits of our competence when our cases overlap into problems of legal and moral involvement and . . . we must seek counsel of the clergy and the legal profession." On the same subject, Dietrich W. Roloff, MD, co-director, Holden Intensive Care Nurseries, the University of Michigan Medical Center, said, ". . . it is important that we do not divorce ourselves and our actions from prevailing views in the society . . . I seems obvious that the days

are gone when these life-support decisions could be made with only the parents' and the physician's involvement. The community and society are attempting to assume a role in these decisions."

Considering the Quality of Life

To what extent should decisions on medical care be based on the "quality of life" the patient can expect to lead? Doctor Ledrick: "I feel very strongly against the quality of life concept, presently, because one cannot be the judge of a particular child's outcome. We have several examples in our community of infants that were 'given up for lost' who have developed quite normally . . . I feel very strongly that any infant has a legal right to his existence. Just because he cannot speak does not mean that he must be the victim of his parents, physicians or legislators . . . I am a little dismayed by those expounding on a quality of life philosophy. The implication of all this is that the physician is becoming the executioner of the problems that society doesn't want to deal with. The preservation of life still needs to be an unconditional obligation on the part of the medical community."

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And Doctor Weir: "What is an 'ordinary person' and how would this imaginary person describe the facets of living required for 'human existence'? Is the severe spastic, the mongol or the post-CVA hemiplegic living a 'human existence'? Many of these people so afflicted think they are living such an existence. Should we physicians try to convince them that they aren't?"

If we make the assumption that "quality of life" or a "tolerable existence" should be taken into account when determining whether or not to perform life saving procedures on defective newborns, how can these terms be defined? Also, what constitutes "extraordinary measures" to save a life? Again, Doctor Ledrick: "One area that needs to be elucidated is the term 'extraordinary means' . . . In a neonatal ICU, all procedures are ordinary to us but extraordinary to the community at large. 'Extraordinary' loses its functional meaning in such a unit."

In the Detroit case cited earlier, was the surgical procedure the parents originally declined in the category of "extraordinary?" Doctor Weir said not. Would another physician in another context say it was; or would Doctor Weir, in another context agree it was an extraordinary measure to save a certain infant's life considering all the circumstances?

What About Guidelines?

Should guidelines for measuring these indefinable terms be attempted? Some physicians expressed the fear that formation of strict guidelines for "quality of life" or "extraordinary measures" might be extremely difficult or, in fact, impossible. Lester Weiss, MD, Henry Ford Hospital, Detroit: "I do not feel that any organization, be it the court or the pediatric society should take away the prerogatives from the physician and the family working in consort to make the appropriate decision for the individual child and family." Doctor Wilson: "I fervently hope that the Academy does not attempt to establish authoritative rules for the government of the conduct of its members especially in certain controversial areas."

But on the other side of this point was John C. Montgomery, MD, of Grand Rapids who, while admitting the difficulty of judging, says, "For the time being I hold the opinion that the only way to deal with such a problem is to employ a hospital (department) committee to discuss pros and cons and present basic hard facts to the parents. The parents alone cannot be expected to be the only ones to make certain critical decisions."

Unanswerable questions, complex ethical dilemmas — these always have been a part of physicians' lives. And every life saving tool added to the physician's repertoire increases the dilemma.

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1. *Demeulenaere, L.: Action du R 1132 sur le transit gastro-intestinal, Acta Gastroent. Belg. 21:674-680 (Sept.-Oct.) 1958.*

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Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

Dosage and administration: ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

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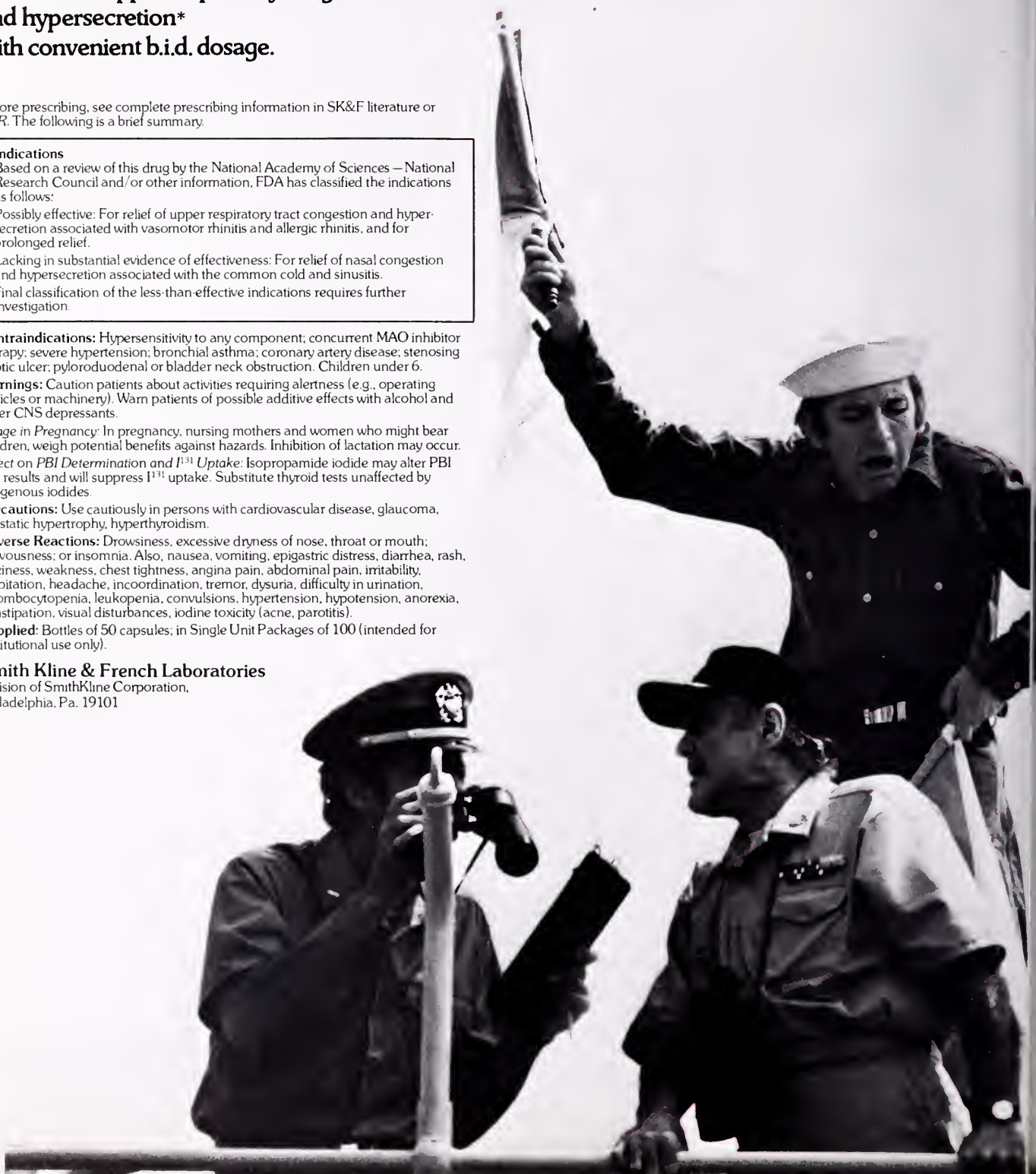

Medicaid, 1972-1974: An Update

By Paul M. Allen, Director
Bureau of Medical Assistance

During the period 1972/73 the state instituted a new series of management information systems for the Medicaid program. Inherent in these systems changes was the assumption by the state of the fiscal agent function.

In their early days the new systems were fraught with many problems concerning provider agreements, billing forms, and the exchange of information between the medical community and program administration. Fortunately, most of these problems have been resolved through a combination of many actions, not the least of which was the establishment of continuing liaison between state departments and professional associations, most particularly the Michigan State Medical Society.

This liaison approach to problem resolution with the medical society is not just rhetoric but is a viable exchange of ideas and constructive criticism. In its early days the dialogue between the society and the state was an almost daily occurrence. At the present time it takes the form of a constant exchange of correspondence and a formal meeting every 90 days between the Medicaid Liaison Committee of the medical society and the directors of the Departments of Social Services and Public Health, the Governor's Office of Health and Medical Affairs, and related state and medical society staff. The most recent meeting of the Medicaid Liaison Committee was held September 18, 1974 at the Michigan State Medical Society headquarters in East Lansing.

Michigan Program One of Largest

In the past two years the Medicaid program in Michigan has grown from annual expenditures of $420 million to a current fiscal year appropriation of $588 million. During this same time, the number of recipients served by the program has grown approximately 10 percent, from a total of 730,000 to slightly over 800,000 persons.

The Michigan Medicaid program is one of the largest and most comprehensive programs in the United States. Within the total population served, approximately 70 percent of the recipients are children or persons over 65 years of age. As a general rule the latter group are eligible for both Medicare and Medicaid, and this group is increasing in size with the advent of the Supplemental Security Income (SSI) program. In addition to children and the elderly, the program serves a significant number of disabled and blind adults.

Aside from inflation in medical prices, the major increase in medical expenses incurred during the past two years for the Medicaid population has been caused by the expansion of benefits to children under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. This program, which was launched in the spring of 1973, has as its immediate objective the periodic medical screening of all Medicaid children in order that medical problems may be uncovered, diagnosed and treated at the earliest practicable time. A by-product of this effort is the major goal of providing needy persons access to the complete spectrum of health care services.

Coincident with the establishment of EPSDT was the expansion of coverage for children to include dental services, vision services and hearing services. As a result, the Michigan Medicaid program is the largest third party payment system for dental services in the state.

The major thrust of the new Michigan Medicaid management systems introduced in 1972 and 1973 was to give all concerned better control over the financial and services delivery aspects of this burgeoning program, and to provide prompt and equitable reimbursement to all providers of medical services.

The state believes quite strongly that most of these objectives have been achieved. The new system is now producing a wealth of management information with respect to the cost of services, the utilization of services, and the quantity of services provided to recipients. This information is current, extremely accurate and has proven to be most invaluable in program administration.

Michigan Program the Best

With respect to the objective of providing prompt and equitable payment to providers, we believe that the Michigan program is the best in the nation. At the present time we are paying 83% of all bills received, regardless of source, within 15 days; 97% of all billings are paid within 30 days.

For example, in the area of physician billings we currently receive approximately 30,000 claims

for service each day. As of the first week in September, 1974, there were only 18,000 physician claims for service that had been in the system over 30 days.

In the same vein, another significant statistic concerns hospitals. Accounts payable to hospitals as of the first week in September were $3.3 million. This represents an equivalent of less than five days worth of hospital billings, since the monthly Medicaid expenditure for hospital services is $16 million.

These results illustrate a prime feature of the new payment mechanism that allows management to quickly isolate and resolve day to day problems. In addition to the fast payment features, ancillary systems provide a wealth of utilization review data that is ideal for program management and data exchange under PSRO concepts.

The state's high opinion of its new system is shared by the federal government, by the rest of the states, and parts of Canada. State officials have been making presentations on the system in Lansing and nationwide to private and public agencies who wish to adapt the Michigan system to their own environment. Besides being efficient the system is most economical. Total *audited* Medicaid costs approximate 35¢ per claim and are the lowest known administrative costs for this type operation.

The concept of future National Health Insurance is a bit murky at this time; whatever form it does take, however, a system such as the one developed for the Michigan Medicaid program will be vital to the success of any expansion of third party payment mechanisms.

Therefore, it is to the advantage of the Michigan medical community and to the state to insure that what has been learned to date in this new approach to medical assistance administration is incorporated into future third party payment processes.

State Drug Programs Licensed

Some 387 Michigan groups and agencies have been licensed by the Office of Substance Abuse Services. Each offers treatment, rehabilitation or prevention services in drug and alcoholism programs. The law creating OSAS under the State Public Health Department last year requires licensing of drug programs, State licensing is necessary for a program to qualify for federal funds. Each of the 465 programs in the state will be inspected through OSAS, though other programs with medical directors are excluded.

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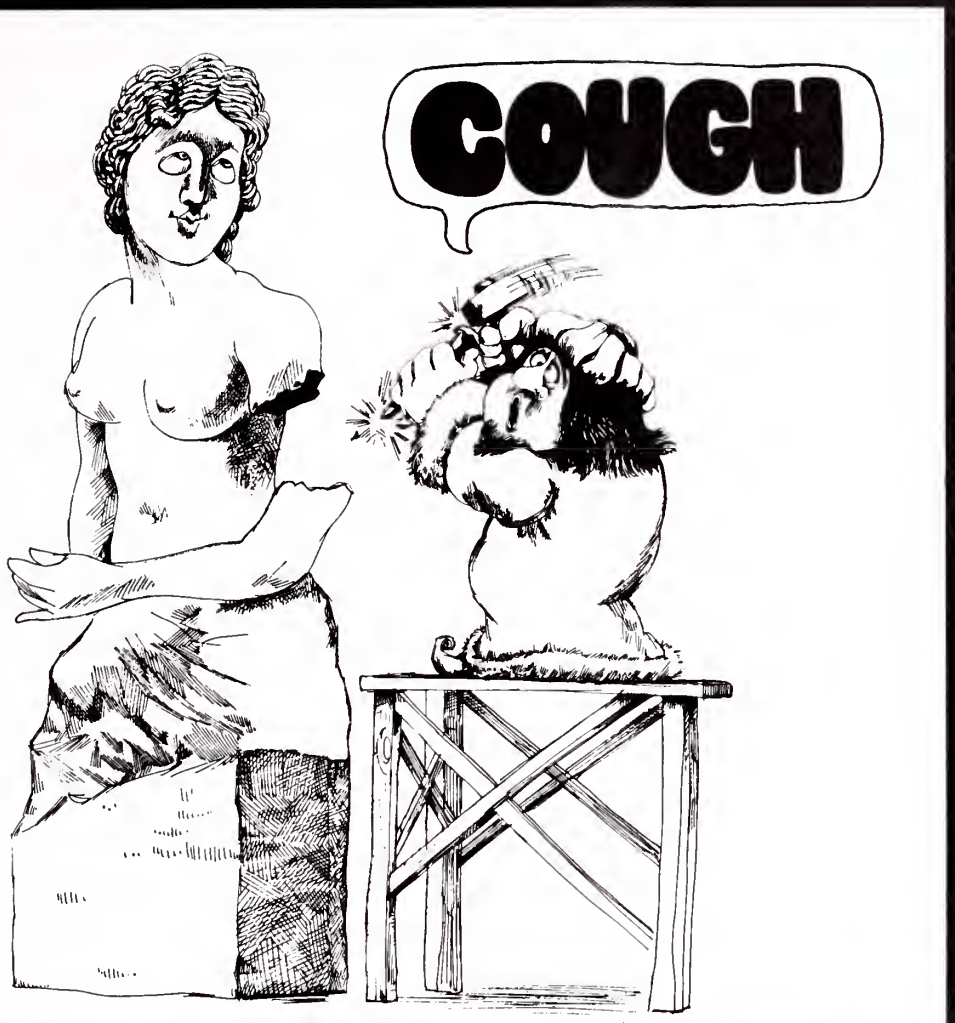

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The Judicial Commission Makes Its 1974 Report

By John W. Grigg, MD
Chairman, MSMS Judicial Commission

Traditionally, the chairman of the MSMS Judicial Commission has presented an annual report to the MSMS House of Delegates. Since the scope of activities of the Judicial Commission is independent of The Council and the House of Delegates, and the commission is a body elected by the Michigan State Medical Society membership, the present chairman believes it is logical to report directly to the members of the Michigan State Medical Society. Following is our 1974 report:

In 1973, the MSMS Judicial Commission established guidelines of current policy subject to the obligations of the Michigan State Medical Society Constitution and Bylaws. These seven policies are not static but subject to amendment from time to time by the commission. These policies are listed so the membership may have a broader understanding of the commission's function.

1. The commission will give favorable consideration to original jurisdiction requests sought by MSMS component societies.
2. The commission will continue to exercise its discretion as to taking cases of original jurisdiction, from whatever source, giving preference to questions and topics of statewide significance.
3. The commission will necessarily give low priority to original jurisdiction requests which appear to deal with isolated instances or non-recurring topics.
4. The commission will not take jurisdiction from complainants who are not Society members, save for infrequent problems which are novel or of grave import.
5. The commission will consider from time to time broad ethical questions, whether on original jurisdiction, or appeal, or whether taken up by the commission on its own initiative.
6. The commission recognizes that many problems of peer review and professional standards can involve ethical concepts which are of direct interest to the commission. Because peer review and professional standards are handled by other bodies, the commission will decline such examinations except under limited circumstances and then only to pass upon ethical questions rather than repeating the professional review.
7. The principles above enunciated also will serve as indicia to the commission's posture with respect to cases sought to be appealed, subject to the necessity for orderly handling of those appellate matters which it is inherently obligated to hear.

The Judicial Commission is responsible for matters of physicians' ethics and personal conduct. In the broad sense, it may be considered the Michigan State Medical Society supreme court of ethics.

Many intriguing problems have arisen during the past year.

A question which has involved considerable of the commission's energies has been the ethics of physician advertising by the Metropolitan Health Plan. The commission assumed original jurisdiction because the advertising campaign involved outstate areas as well as the metropolitan and suburban Detroit areas.

The Metropolitan Health Plan is sponsored by Michigan Blue Shield. Its advertising campaign was subsidized by Michigan Blue Shield. A vigorous advertising campaign of the Metropolitan Health Plan was initiated in the fall of 1973. A formal complaint was received by the Judicial Commission against the advertisement of physicians' and surgeons' services.

After a study of the available advertising copy, it was the unanimous opinion of the Judicial Commission that the advertising of physicians' and surgeons' services by the Metropolitan Health Plan was in direct violation of the Principles of Medical Ethics which prohibit physicians and surgeons from advertising their services whether in solo or group practice. The commission concluded that those physicians involved with the Metropolitan Health Plan were committing a breach of ethics.

The commission further concluded that the advertising by the Metropolitan Health Plan subsidized by Michigan Blue Shield significantly differed from the general Blue Shield advertising in the past. The Metropolitan Health Plan advertised only services offered by the Metropolitan Health Plan contracted by the Metropolitan Hospital, and the physicians employed by the hospital; i.e., services provided only by certain physicians on a restricted basis and not services which can be obtained through any physician in the state.

Lengthy communications transpired from the

commission to the president of Michigan Blue Shield, John C. McCabe; the president of Michigan Hospital Service, Bennett J. McCarthy, M.D.; chairman of the Board of Directors of Michigan Blue Shield, Robert Hamburg, M.D., and the executive director of the Metropolitan Health Plan, Robert Reveley. These communications culminated in a meeting of the Judicial Commission with Louis Hayes, M.D. and Robert Reveley. At that meeting, the specifics of the Judicial Commission's objections to the advertising campaign by Metropolitan Health Plan were outlined.

No complaints of unethical advertising by the Metropolitan Health Plan have been received by the Judicial Commission during the past three months. The commission to date has not formalized charges of unethical conduct against the physicians involved in the Metropolitan Health Plan.

The Judicial Commission is going to take a more aggressive stance in the area of physician advertising, especially in instances where various groups are advertising the services of physicians and surgeons. We will pursue the problem of abortion clinics which are doing such advertising, in particular.

A recurring problem is the failure of some local medical society ethics committees to adequately pursue complaints, and to conduct hearings where the complainant is given the opportunity to appear and be heard. This is basic to any fair, adequate investigation.

Many complaints against physicians are initiated by individuals with emotional instability, but there are also those complaints which are unfortunately true. It is for the betterment of our profession if these complaints are investigated and resolved. The profession must recognize the occasions of dishonesty, incompetency, overcharging, professional misbehavior, and have the fortitude to discipline them.

In the past there existed little means to discipline wayward colleagues except expulsion from the medical society. The commission is presently establishing policy for liaison with the Michigan Medical Practice Board for those cases which are brought to the commission's attention involving possible fraud, professional incompetence, and professional misconduct.

One of the more esoteric questions presented to the commission was the ethics of restrictive covenants in a physician's building lease. Specifically, is it a breach of ethics for a physician to demand a clause in the building lease to exclude other physicians of that same specialty or nature to lease space in the same building? After consultation with the AMA Judicial Council, it was the decision of the commission that it is not unethical for physicians to request such a restrictive covenant. In our deliberations, it was noted that while this is not unethical, it may not be legally enforceable, but this has no bearing on the ethics of the question.

Although reports from the AMA Judicial Council on "Death" and "The Physician and the Dying Patient" were received only as information, we fully concur with their recommendations and submit them to the membership for edification. Both reports were adopted by the AMA House of Delegates.

"Death"

Recommendations

1. The Judicial Council recommends that the House of Delegates adopt the position that, at the present, statutory definition of death is neither desirable nor necessary.
2. The council recommends that state medical associations urge their respective legislatures to postpone enactment of legislation defining death by statute, and
3. The Council further recommends that this House of Delegates affirm:
   "Death shall be determined by the clinical judgment of the physician using the necessary available and currently accepted criteria."

"The Physician and the Dying Patient"

Recommendations

1. The Council recommends that the several state, county and specialty medical societies encourage and promote discussions of the reciprocal rights and duties of physicians and patients suffering terminal illness.
2. The Council recommends that the House not endorse any particular form to express an individual's wishes which relate prospectively to his final illness, but recognizes that individuals have the right to express such wishes.

   Physicians may, and indeed should, be encouraged to discuss death and terminal illness with patients. Physicians may, and indeed should, respect expressions of patients' wishes regarding medical care during terminal illness but may, and indeed should, feel free to question those wishes with patients' competent legal representative or by appropriate judicial proceedings when the circumstances of a particular situation seem to require it.

   The Council recommends that the House adopt the following statement to serve as a guideline for physicians:

   The intentional termination of the life of

Michigan's Betty Lou Willey AAMA President

Betty Lou Willey received National President's Award from MSMS Council Chairman Robert M. Leitch, MD, at MSMS Scientific Meeting ceremonies.

Michigan has the honor of being the home state of the national president of the 15,500 member American Association of Medical Assistants.

She's Betty Lou Willey, office manager and medical assistant to Doctors William T. Davison and Juan E. Olivera, Port Huron. Her name is familiar to most Michigan physicians as she has been active for many years with the national medical assistants' association.

Mrs. Willey was installed in ceremonies this fall during the national convention of the AAMA in Denver. She previously had served as AAMA speaker for five years, and also as vice speaker, vice president and president-elect, treasurer, recording secretary, speaker and parliamentarian of the Michigan state chapter of the AAMA.

In addition, she is the founding president and member of the organizing committee of the St. Clair County Medical Assistants Chapter and has chaired many of its committees.

Interviewed just before her installation, Mrs. Willey said, "I am absolutely thrilled and honored to have attained such a position in a national organization. Being president will keep me busy but I'm still going to keep on working."

Mrs. Willey sets as her main goal the development of guided study and inservice education programs for medical assistants now being planned by the AAMA. "My fondest dream is to have those programs finished this year," she says.

The programs would offer study in anatomy-physiology-terminology, human relations for medical assistants, medical law and ethics for medical assistants, and communications. They will be aimed especially at medical assistants without ready access to college or university facilities and who would like to pursue individual study.

Mrs. Willey also anticipates considerable traveling during the year, with plans now to attend several state medical assistant conventions, the AMA clinical and annual conventions and national-level meetings to develop certification tests in medical specialties for medical assistants.

"It's going to be an exciting year," she says.

The AAMA is a national organization of medical assistants employed in either administrative or clinical capacities in doctors' offices throughout the country. Its programs of continuing education include an annual certification examination offered in more than 70 centers throughout the country.

The AAMA also collaborates with the AMA in evaluating educational programs for medical assistants in order to establish and maintain curriculum standards. Currently, there are 74 accredited programs.

JUDICIAL COMMISSION/Continued

> one human being by another — mercy killing — is contrary to that for which the medical profession stands and is contrary to the policy of the American Medical Association.
>
> The cessation of the employment of extraordinary means to prolong life of the body when there is irrefutable evidence that biological death is imminent is the decision of the patient and/or his immediate family. The advice and judgment of the physician should be freely available to the patient and/or his immediate family.

A not infrequent complaint by members of the Michigan State Medical Society is that the state medical society and the American Medical Association policies are not in tune with the needs of the individual members — that we are slow to evaluate, explore, and initiate new concepts and ideas within our society's political structure, and in delivering health care in today's modern society.

While the basic principles of medical ethics have been established since Hippocrates, it is the aim of the Judicial Commission to be responsive with prudent flexibility to the problems of ethical and professional conduct by members of this society.

DO YOU NOTICE ANYTHING SPECIAL?

He is one of the more than 60,000 members of the family of MESSA – Michigan Education Special Services Association – who reside in every county of the state of Michigan.

He belongs to an insurance program which is in effect in 525 school districts.

He is a participant in a hospitalization plan which allows a maximum of ONE MILLION DOLLARS of coverage for eligible in-hospital expense, including: diagnostic x-rays, laboratory work, intensive care, burn and cardiovascular units. Also, alcoholism and drug addiction, mental and nervous disorders are covered as any other illness.

MESSA is an affiliate of the Michigan Education Association, providing group medical insurance programs to qualified school employees and their families. Since 1938, MESSA has anticipated and met the health insurance needs of Michigan educators. Super Med2 Major Medical Expense insurance is designed by MESSA and underwritten by The Mutual Benefit Life Insurance Company, Newark, New Jersey.

For details of coverage, including exclusions and limitations, please contact MESSA at (800) 292-4910.

The next time you meet a MESSA member, you'll notice something special !!!

the family of messa

A Chiropractic Primer

The following was excerpted from an article appearing in the April, 1974, Illinois Medical Journal.

Who invented Chiropractic?

Chiropractic was invented by Daniel David Palmer, an Iowa grocer. In 1886, he set up a "magnetic healing studio" to find what he felt was Nature's Great Secret — *the* cause of human disease.

The "art" of chiropractic was born in 1895, when Palmer examined a janitor who was deaf and *found* a "subluxated" (misaligned) vertebra in his spine. He applied firm pressure to the vertebra with his hands, the vertebra moved back into place "and soon the man could hear as before." The word "chiropractic" comes from the Greek "chiero" ("by hand") and "praktikos" ("to do").

What is Chiropractic?

Chiropractors believe *all* disease is caused by "luxated bones," mostly in the spinal column. "By their displacement and pressure they elongate the pathway of the nerve . . . displacing it from a direct line. This pressure creates tension, increased vibration, consequently an increased amount of heat. Heat alters tissue; altered tissue modifies the transmission of impulses; modified impulses cause functions to be performed abnormally."

Treatment consists of "adjustments" of the spine — twisting, pulling, stretching, massage, — to eliminate a "subluxation," or accomplish a "spinal adjustment."

Who are the "Straights," the "Mixers"?

The straights (International Chiropractic Association) believe that adjustment alone deals with and eliminates disease. The mixers (American Chiropractic Association) believe that additional physical and nutritional treatment also is necessary.

How do Chiropractors diagnose?

Chiropractors claim to be able to cure some 95 conditions and decry such things as immunization, claiming that polio, smallpox, diphtheria, and all communicable diseases would never be transmitted to a person with a completely aligned vertebral column. The average number of adjustments given by the chiropractors for various disorders ranges from a low of 28.2 for acne to 84.1 for jaundice.

How is X-ray used?

The usual chiropractic visit includes an X-ray known in the trade as a "spinography." Most are 14-by-16 inch chest shots, which are mounted on a screen and sectioned off into two-inch squares to help visualize disturbances in the longitudinal alignment of the vertebral column. Chiropractors claim these X-rays locate problem areas, called "subluxations" in the spinal column. Chiropractic examinations average two exposures.

What is Chiropractic training like?

Chiropractic schools offer a four-year course leading to a Doctor of Chiropractic degree. The first two years mainly cover basic science subjects, with some outpatient clinical exposure at the end of the second year. The last two years deal almost totally with chiropractic and outpatient care.

Until this fall, none of the 10 colleges of chiropractic was accredited, recognized or listed by either of the two national education bodies that recognize agencies that accredit institutions of higher education in the U.S. Now one, the National College of Chiropractic, Lombard, Ill., is accredited by the North Central Association.

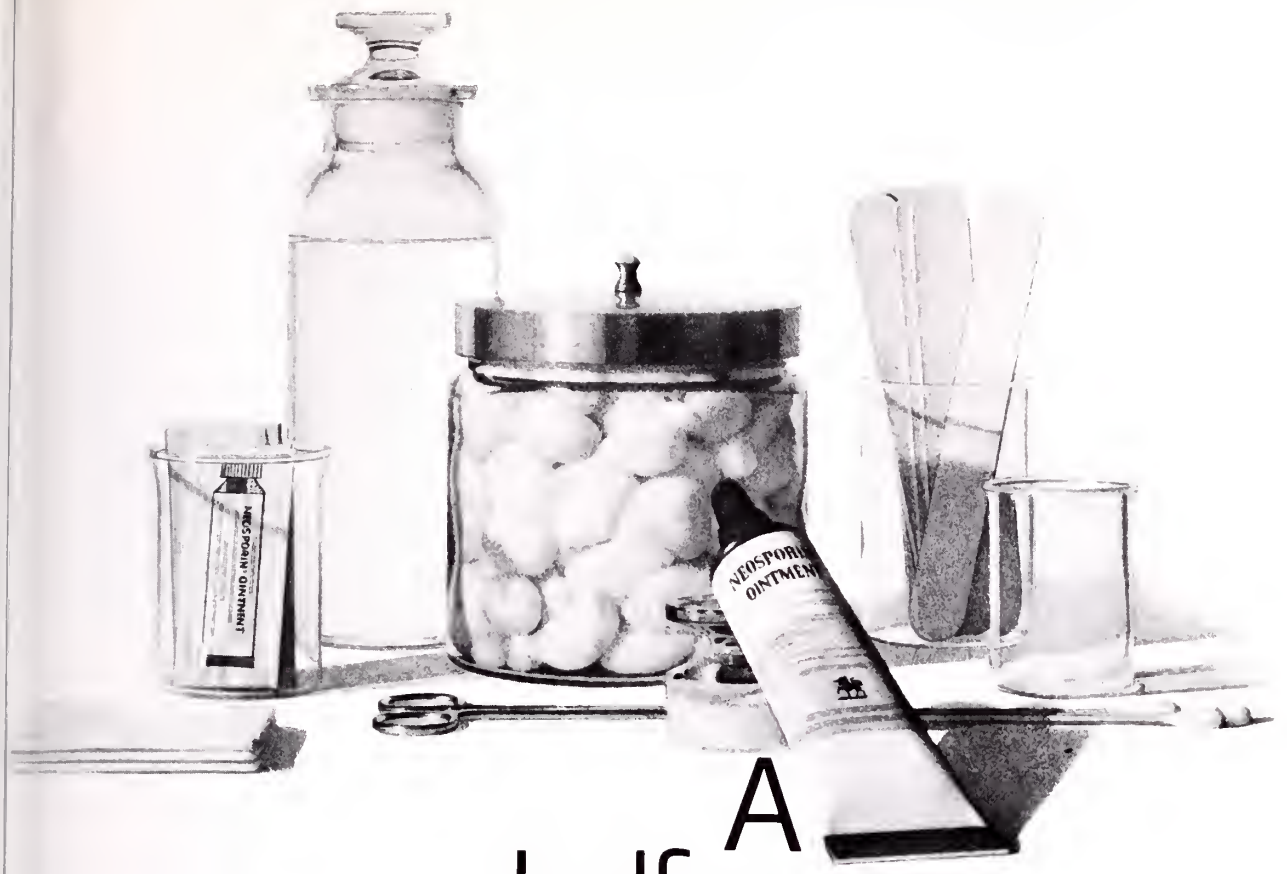
What about Chiropractic lobbying?

State and county chiropractic groups receive expert help and strong back-up from the two national chiropractic associations. Much of their programs are oriented toward political action, and the activities are guided by political veterans who have the experience and the contacts. The executive director of the American Chiropractic Association is Norman A. Erbe, former governor of Iowa.

What appeal does Chiropractic have?

Despite the advances of modern medicine, many unknown factors remain. In many instances the appeal of chiropractic treatment is made on these unknown factors.

The medical doctor often must tell a patient that treatment may take a long time; that the disease is complex; that treatment will be expensive; that the disease may be incurable. The chiropractor might say his relief will be speedy, that the disease is simple. His treatment may cost less and he may say he will give permanent or lasting treatment.



A half-ounce of prevention

Use it to prevent a topical infection. Or to treat one that's already started. In either case, it's good medicine. Whether for lacerations, burns, open wounds, IV catheter or surgical aftercare. Neosporin® Ointment provides broad antibacterial coverage against common susceptible pathogens. And since it contains three antibiotics that are rarely used systemically, the risk of sensitization is reduced. Neosporin Ointment. A half-ounce of prevention. Also available in a full ounce of prevention and in convenient foil packets.

Neosporin Ointment carried on Apollo and Skylab missions.

Neosporin® Ointment
(polymyxin B-bacitracin-neomycin)

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs.
In tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

INDICATIONS: *Therapeutically,* used as an adjunct to appropriate systemic therapy for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) traumatic lesions, inflamed or suppurating as a result of bacterial infection. *Prophylactically,* the ointment may be used to prevent bacterial contamination burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

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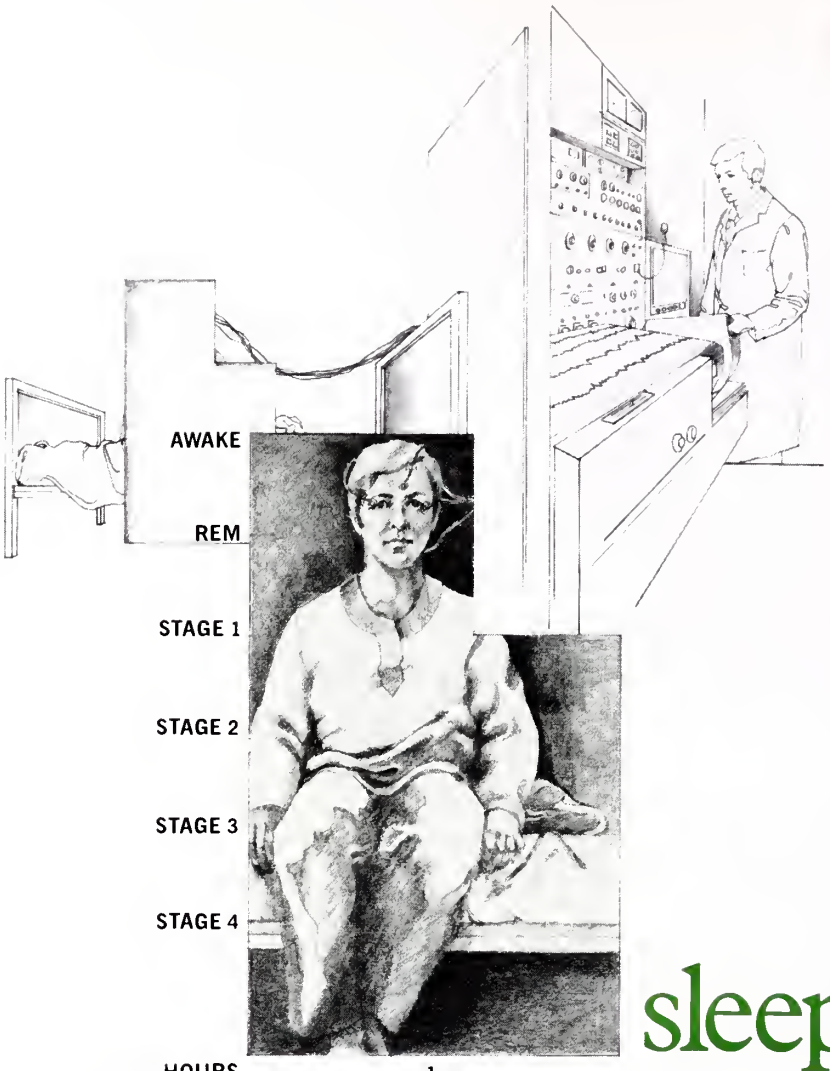


sleep begins within 17 minutes, on average...

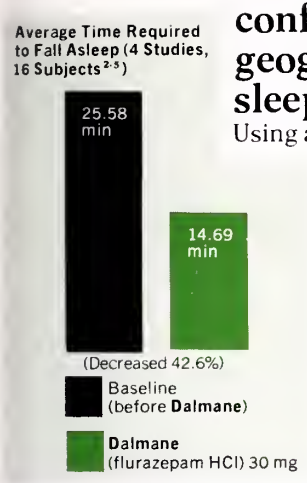
an initial benefit of

Dalmane®

(flurazepam HCl)

proved by a 22-night clinical study of insomnia patients in the sleep research laboratory and at home[1]

Three insomnia patients selected for difficulty falling asleep were administered Dalmane (flurazepam HCl) 30 mg for 14 consecutive nights. Placebo was given for four nights prior to and four nights after Dalmane. Physiologic tracings on Dalmane nights 1-3 showed sleep induction time averaged 13.90 minutes; on Dalmane nights 12-14, 18.80 minutes. Combined average for the 6 monitored drug nights was 16.35 minutes.[1]


Average Time Required to Fall Asleep (4 Studies, 16 Subjects[2-5])
25.58 min
14.69 min
(Decreased 42.6%)
Baseline (before Dalmane)
Dalmane (flurazepam HCl) 30 mg

confirmed by clinical studies in four geographically separated sleep research laboratories[2-5]

Using a 14-night protocol involving eight insomniac and eight normal subjects, four studies confirmed the sleep-inducing effectiveness of Dalmane (flurazepam HCl) and the reproducibility of this response. On average, one 30-mg capsule induced sleep within 17 minutes. In all these studies, Dalmane induced sleep rapidly, reduced nighttime awakenings, and provided 7 to 8 hours of sleep without repeating dosage[2-5]

Dalmane (flurazepam HCl) induces and maintains sleep, with relative safety

Dalmane is generally well tolerated; morning "hang-over" has been relatively infrequent. While dizziness, drowsiness, lightheadedness and the like have been noted most often, particularly in the elderly and debilitated, physicians should be aware of the possibility of more serious reactions, as noted below.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

when restful sleep is indicated

Dalmane®
(flurazepam HCl)

One 30-mg capsule *h.s.* — usual adult dosage (15 mg may suffice in some patients).
One 15-mg capsule *h.s.* — initial dosage for elderly or debilitated patients.

- induces sleep within 17 minutes, on average
- reduces nighttime awakenings
- sustains sleep 7 to 8 hours, on average, without repeating dosage

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5. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ

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Opinion & Dialogue

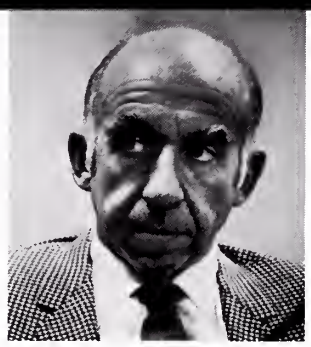
The Role of the Detail Man

Dr. Willard Gobbell
Family Physician
Encino, California

"I may be prejudiced, but I am very much in favor of the detail mer I meet. Most of them are knowledge able about the drugs they promote and can be a great help in acquaint ing me with new medication."

Family Physician's Perception

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most of the men who visit me regularly and they in turn have become aware of my particular interests and the nature of my practice. They, therefore, limit their discussion as much as possible to the areas of interest to me. Since I usually see the same representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date information about his products.



Dr. Jeremiah Stamler
Chairman
Department of Community Health and Preventive Medicine, and Dingman Professor of Cardiology
Northwestern University Medical School

"In the total picture of dealing with health problems in this country there is a potential for detail men to play a meaningful role."

The Positive Influence

My contact with representatives and salesmen of the pharmaceutical industry is the type of contact that people in a medical center research people, and academic people have and that's in all likeliho on a somewhat different level from that of the practicing physician.

Let me touch on how I personally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be—and at times actually are—disseminators of useful information. They could consistently serve a real educational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets—some of it scientifically sound and therefore truly useful—as well as some excellent films produced by the pharmaceutical industry. When they function in this

Is He a Source of Information?

Yes, with certain reservations. The average sales representative has a great fund of information about the drug products he is responsible for. He is usually able to answer most questions fully and intelligently. He can also supply reprints of articles that contain a great deal of information. Here, too, I exercise some caution. I usually accept most of the statements and opinions that I find in the papers and studies which come from the larger teaching facilities. It goes without saying that a physician should also rely on other sources for his information on pharmacology.

Training of Sales Representatives

Ideally, a candidate for the position as a sales representative of a pharmaceutical company should be a graduate pharmacist who has a questioning mind. I don't think this is possible in every case, and so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

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capacity they are indeed useful; particularly in the fact that they disseminate broadly based educational material and serve not just as "pushers" of their drugs.

The Other Side of the Coin

Obviously, the pharmaceutical companies are not producing all this material as a labor of love—they are in the business of selling products for profit. In this regard the ambitious and improperly motivated sales representative can exert a negative influence on the practicing physician, both by presenting a one-sided picture of his product, and by encouraging the practitioner to depend too heavily on drugs for his total therapy. In these ways, the salesman has often distorted objective reality and undermined his potential role as an educator.

The Industry Responsibility

Since the detail man must be an information resource as well as a representative of his particular pharmaceutical company, he should be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.,* the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

PMA

Commentary

Physicians must lead changes in medical world

By George W. Slagle, MD
Battle Creek

(The following remarks are excerpted from an address presented by Doctor Slagle on his installation this summer as president of the Forum for Medical Affairs.)

Never in history has there been a stronger demand for health care and its availability, as well as its accessability to everyone in the United States. If medicine does nothing more than recognize the swelling population, the ever-increasing awareness of the people of research and scientific advances, the changes — subtle and obvious — taking place economically and sociologically, the need to move forward with these changes becomes self-evident.

Medicine must recognize its function as most vital within a given community. We must organize our policies for the delivery of medical care and adjust our attitudes around the principles of community life.

We've got not only to recognize the market for our services but to compete for it. We must learn to know what works within the community, what is likely to succeed, what is acceptable by the majority and then capitalize on and exploit it.

Who is better qualified to recognize the health needs of a community? The answer is obvious — the doctors! If health needs are to be met fully, honestly, practically, completely and unequivocally, then the doctor must be the captain — the skipper!

Doctor Slagle

Where health needs are concerned, we should and must fight to assume leadership. It is not there for us to grab — but it belongs to us. We must compete for it.

We cannot keep crying a pathetic, "Please no change." Or "Leave medicine to doctors. We are doing the best we can." We cannot be given the staff of leadership in a world whose needs have outgrown the methodology of care that is being provided today. We cannot drag our feet in the area of change.

If we really are concerned about the patient, then we will see to it that the program of change is formulated along guidelines that will protect the patient and allow medical care to be accessible to everyone within the community. We will see to it that health care is delivered properly and promptly to everyone in need.

Further, if change means abolishing some of the medical practices as we know them today and organizing groups for more comprehensive care, and a better control of its fiscal administration, then so be it! There must be more than a cursory concern for the patient's ability to pay.

Medicine for the masses will need the combined expertise of business, engineering, systems analysis, architects, technicians, and medical men of vision to deliver care where and when it is needed on a 24-hour basis. Therefore, the practical and logical steps of change must be thought out carefully. It must be organized regionally because no one plan will apply equally in all communities.

The academician can no longer subtract himself from these concerns. He must become a part of the plan of change. He must prepare the medical student to embrace the yoke of community responsibility, along with the wreath of ministry of healing and carry them both on shoulders that are stronger and more erect than other men. The student must be imbued with integrity, responsibility, concern and dedication. He must consider patient care as a privilege rather than a burden.

The task still is enormous and I feel that physicians are better qualified to provide the solutions. Physicians have the firmness of purpose and the integrity to move to delete those procedures which prove inadequate or improper and then provide alternatives. Physicians more than any other arm of the community have the dedication to undertake the perpetual evaluation of the needs and the services filling those needs. Who can and will have more concern for the patient and the patient's ability to pay for his health care?

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Mission Accomplished–

Michigan Cardiac Care Unit Project Establishes 82 New CCU Beds

The following report on the Cardiac Care Unit Project is made by Ralph Lewis, MPH, Ann Arbor, project coordinator and director of the Michigan Medical Schools Council of Deans; Park W. Willis, III, MD, project director and director of the Section of Cardiology, University of Michigan Medical Center; Irwin J. Schatz, MD, associate director, University of Michigan Section of Cardiology; E.W. Reynolds, Jr., MD, director of clinical cardiology at the University of Wisconsin Medical School and project director during the first year and a half of the project; Donald Kraushaar, MHA, field director and Jeanne Copp, MA, project evaluator.

In 1969, the University of Michigan and the Michigan Heart Association jointly initiated the Michigan Comprehensive Cardiac Care Unit Project. Project activities continued through July 31 of this year on a reduced scale, as coordinators maintained the data collection and reporting system, thus completing the education and evaluation phases of those cardiac care units opened during the project's last fiscal year and continuing nursing education and physician consultation.

The W.K. Kellogg Foundation sponsored the entire project including grants to the hospitals involved, administrative and training costs.

Summary

During the course of the four-year Michigan Comprehensive Cardiac Care Unit Project, 76 new cardiac care unit (CCU) beds were established and are now in operation in 27 Michigan hospitals. Planning efforts were completed for six more beds in two hospitals.

Each of these hospitals received financial assistance from the W.K. Kellogg Foundation, on a matching basis, to help establish a CCU. In addition to the training and consultation given the 27 hospitals which received funds, educational services were made available to the staff of 28 other community hospitals.

Total funds granted to hospitals by the Kellogg Foundation were $394,781. They were matched or exceeded by the participating hospitals. The original goal of the project was to establish 60 CCU beds; then the Kellogg Foundation provided an additional $100,000 to establish another 20 beds. When the two additional hospitals obtain planning approval, a total of 82 beds will have been provided, surpassing our goal.

Education, Training and Consultation

Physician and nurse training activities have been the project's cornerstone. Almost without exception, project hospitals have received some physician and/or nurse consultation or education. Formal courses, bedside teaching, and telephone communication provided expert consultation at the project hospitals. Early in the project the education and consultation effort was taken to the community.

A significant contribution to the project's success was made by private physicians who volunteered training and consultation for personnel in project hospitals. Approximately 50 Michigan physicians assumed these training responsibilities. For all it was a commitment to education.

New relationships for medical consultation have been established as a result; physicians have remained in contact with project hospitals to perform services such as electrocardiogram interpretation, pacemaker implantation, and other modern cardiology functions.

Physician education programs were completed in the 23 hospitals now operating CCUs and are at various stages of completion in the additional four hospitals. In addition, the project has provided significant in-service training in 10 non-project hospitals that were operating CCUs before the project was launched or that have requested additional continuing education. The University of Michigan Department of Postgraduate Medicine and Health Professions Education has offered short courses each year in general coronary heart disease attended by physicians from Michigan hospitals contacted by project staff. A cooperative program with the Michigan Heart Association, in the Upper Peninsula, helped expand the project to that area.

The role of the nurse in cardiac care has changed significantly. The nurse is now called on to make decisions and perform functions in diagnosis and inpatient care previously limited to the physician. Nowhere are these new responsibilities more clearly demonstrated than in the cardiac care unit where success depends upon the nurse.

Where does the nurse in the small community hospital gain insight into these constantly changing roles? The project has been of help by providing a major link between the hospital and nurse and modern coronary care concepts.

It is difficult to predict the ultimate impact of the project. It has been our goal to insure a sound continuing education program in coronary care policies and practices for the nurse. Hopefully, this will be a lasting result of the project.

Through subcontracts to the Michigan Heart Association and its Grand Rapids Heart Unit, education programs for physicians and nurses were conducted in cooperation with a nurse education project funded by the Michigan Association for Regional Medical Programs, Inc. We feel that this blend of financial support may be unique and certainly it contributed importantly to the success of the overall project.

Research

The grant provided the ability to experiment and demonstrate new ideas in CCU patient care. Methods were developed for the detection of ventricular premature beats in patients with coronary artery disease so that a larger number of patients could be studied for the events that precede a major ventricular arrhythmia; antiarrhythmic drugs were studied in preventing both ventricular premature beats and more complex ventricular arrhythmias.

In addition, a special purpose hybrid computer was built, and during a pilot study ECG signals and other data were transmitted from the CCU at Midland Hospital to the University Hospital. This was to study the feasibility and costs of remote monitoring on a 24 hour basis, which proved both practical and economical.

Research was done on the R-R interval histogram and the factors causing sudden death in ischemic heart disease. A special study was done of the factors associated with digitalis use for myocardial infarction patients being treated in a CCU. Other data obtained were of value in determining sampling error when periods of less than 24 hours were used for rhythm monitoring and in determining diurnal variations in ventricular premature beat frequency.

Evaluation

When the project began in 1969 the usual mortality during hospitalization for acute myocardial infarction was 30-40%. This was an overall figure for patients receiving usual general hospital care. When a CCU was established hospital mortality for patients was found to drop by 15 to 25 percent. As a prerequisite to consideration for participation in our project each hospital staff was asked to determine recent hospital mortality of patients with myocardial infarction (prior to establishment of the CCU). In project hospitals this mortality estimate was usually about 40%.

We evaluated mortality during the CCU phase of hospitalization for acute myocardial infarction. Fifty to 85 percent of deaths during hospitalization for acute myocardial infarction occur within the first five days of admission to the hospital. The average stay in a project hospital CCU was about five days. Thus, we have assumed that the hospital mortality in project hospitals is 18 to 100 percent greater than CCU mortality.

By the end of June 1973, we had collected data on 6,323 patients treated in 27 cardiac care units in Michigan. From the 23 project hospitals included we have data on 3,472 patients of whom 1,504 had acute myocardial infarction. The CCU mortality for patients with acute myocardial infarction in these hospitals has, over the years constantly been about 14%. On the basis of the assumption in the preceding paragraph we estimate a total hospital death rate of 17 to 28 percent. (Unfortunately, exact data on hospital mortality for these patients is not available.) Thus, it would seem that there has been a reduction of between 3/5 and 1/3 in total hospital mortality (from 40 percent to between 17 and 28 percent) after the introduction of these special care units.

Continuing Activities

It is hoped that the project will obtain funds from other sources to allow the evaluation to continue and to maintain the integrity of the present CCU network. This will permit the education and evaluation program to continue their efforts to maintain the highest possible level of patient care.

"I don't have to take the Hippocratic Oath. I'm Hippocrates."

PEOPLE

Donald G. Albert, MD, Royal Oak,

is new president of the Michigan Heart Association.

H. Amjad, MD, O. Bigman, MD, and H. Tabor, MD, Royal Oak,

are authors of "Unilateral Pulmonary Edema," a brief report appearing in the Aug. 19 issue of the *Journal of the American Medical Association.*

R.S. Aronsohn, MD, and R.H. Nishiyama, MD, Ann Arbor,

are authors of "Embryonal Carcinoma," a brief report appearing in the Aug. 19 issue of the *Journal of the American Medical Association.*

Roger Boles, MD, Ann Arbor,

is new chairman of otolaryngology at the University of California, San Francisco. His appointment was effective Sept. 1. Doctor Boles has been professor of otolaryngology at the U-M Medical School and a member of the U-M faculty since 1963.

Sidney Goldstein, MD, formerly of Rochester, N.Y.,

is new head of the Henry Ford Hospital Division of Cardiovascular Diseases.

Paul Hollister, MD, of East Lansing,

has been named medical director for professional services at Michigan State University's College of Human Medicine. Professional services receives patient referrals directed to clinicians on the faculty. A hematologist, Doctor Hollister is assistant professor of medicine.

A. Martin Lerner, MD, Detroit,

contributing to the *Medical Opinion* magazine, has suggested that physicians be re-examined at least every 10 years for medical competency and knowledge. Doctor Lerner is chief, Hutzel Hospital Department of Medicine.

M.C. Levine, MD, Flint, and D.W. White, MD, East Lansing,

are authors of "Chronic Postmyelographic Headache," a clinical note published in the Aug. 5 issue of the *Journal of the American Medical Association.*

Paul Lowinger, MD, Detroit,

is new project director of a prison health project at San Francisco General Hospital and as-

(Continued on page 700)

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sociate professor of psychiatry at the University of California School of Medicine. Doctor Lowinger had been associated with the WSU Department of Psychiatry, the Lafayette Clinic and the Detroit Model Neighborhood Drug Abuse Program.

Patric E. Ludwig,

president-designate of the Michigan Hospital Association, joined the organization in Lansing early in September. Mr. Ludwig will take over on the retirement on Jan. 1 of H. Allan Barth, MHA chief executive for 27 years.

Dorothy M. Mulkey, MD, of Flint,

has been appointed assistant dean of the Michigan State University College of Human Medicine for the Flint campus. She had held the position on an acting basis since last summer. She joined the MSU medical faculty in 1972.

Hermann Pinkus, MD, Detroit,

of the WSU Department of Dermatology, is the recipient of the Stephen Rothman Award for distinctive achievement in dermatological research of the Society for Investigative Dermatology. Doctor Pinkus is presently on a one-year sabbatical as MacFarlane Visiting Professor of Experimental Medicine at the Royal Infirmary, the University of Glasgow.

Stephen N. Preston, MD, Ann Arbor,

is new director of the medical affairs division, Parke, Davis and Company. Formerly director of clinical research at the firm's research laboratories, Doctor Preston is succeeded by Robert A. Buchanan, MD, Ann Arbor.

Junius Mott Rawlings, MD, Detroit,

has retired as associate professor of the WSU Department of Gynecology and Obstetrics. Doctor Rawlings was on the WSU faculty for five years and is former Flint assistant health director.

Joseph A. Rinaldo, Jr., MD,

is new president of the American Society for Gastrointestinal Endoscopy. Doctor Rinaldo also is Providence Hospital Medical Director.

Yvan J. Silva, MD, Detroit,

is current president of the American Association of Foreign Medical Graduates.

Chris J.D. Zarafonetis, MD, Ann Arbor,

is a recipient of the Legion of Merit for outstanding service in the U.S. Army Medical Corps. Doctor Zarafonetis was honored upon his retirement from 36 years of Army service. He has carried on that career while also serving as U-M professor of internal medicine and director of the Simpson Memorial Institute.

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MATERNAL HEALTH DESK REFERENCE CARD NO. 4

(Revised 9/19/74)

(Sponsored and Prepared by the Committee on Maternal Health, Michigan State Medical Society)

SUGGESTED STANDARDS OF PRENATAL CARE

1. Careful comprehensive prenatal care, adequate nutritional intake and accurate *detailed records* significantly reduces maternal and natal wastage. These are especially important in low socio-economic sectors.
2. Aims of Prenatal Care:
   a. Maintenance, or if indicated, early preventive measures for the improvement of the mother's physical, emotional and nutritional health.
   b. Health education of patient during prenatal visits for optimal delivery preparation in order to provide a more satisfying experience.
3. Principles of Adequate Comprehensive Care:
   a. Early commencement of prenatal visits.
   b. Full history is to be taken and recorded including previous illnesses, family, social and nutritional data. Detail of previous pregnancies, menstrual patterns, immunization records, and status of the present pregnancy must be included.
   c. A *complete* physical examination must be *recorded* and should include pelvic examination, clinical pelvimetry and a correlation of uterine size with weeks of gestation.
   d. Assessment of risk factors. Many factors must be taken into consideration including:
      1. Malnutrition, obesity or anemias.
      2. Under 17 years — over 35 years of age.
      3. Diabetes, hypertension, cardiovascular-renal disease, and tuberculosis.
      4. Previous fetal wastage or poor obstetrical history.
      5. High parity (5 or more).
      6. Low socio-economic status.
      7. More than one pregnancy in a year.
      8. Late commencement of care.
   e. Devise a program of prenatal care, program visits and special laboratory studies according to risk factors.
   f. Full and complete chronological records must be in the obstetrical department four weeks prior to due date.
4. Routine Screening Laboratory Studies:
   a. Hematocrit-hemoglobin.
   b. Urinalysis; microscopic evaluation, if indicated.
   c. Rubella titer.
   d. Sickle cell prep, if indicated, and if positive hemoglobin electrophoresis.
   e. Serologic tests for syphilis.
   f. Major blood group and Rh typing, antibody screening for Rh and other antigens.
   g. Papanicolaou smear.
   h. Other frequently needed screening tests include:
      (1) Tuberculin test.
      (2) Cultures for gonococcus.
      (3) Genetic counseling and screening if previous genetic anomalies or with advanced maternal age.
      (4) Glucose tolerance tests, blood chemistry, renal function studies.

5. Immunization boosters or primary immunization may be given during prenatal care. However no live virus immunization may be used. Rubella vaccine is absolutely contraindicated three months prior to and during pregnancy. Refer to desk reference card No. 18.

6. Early consultation is warranted when pregnancy is complicated by diabetes, cardio-renal, and other chronic illnesses. Close cooperative recorded supervision is required during the pregnancy, labor-delivery and the puerperium. The obstetrician is responsible for the total care of his patient during pregnancy.

   Continuity of care requires *detailed written records.*

7. Lifetime dietary habits as well as the foods eaten during the pregnancy have great influence on the fetus and the outcome of the pregnancy.

   a. Weight reduction is contraindicated during pregnancy; however, excessive weight gain often indicates improper nutrition.

   b. Pattern of weight gain is of greater importance than total gain. 22-27 lbs. total weight gain is beneficial. A 3½ lb. weight gain per month during last two trimesters is acceptable.

   c. Diuretics should not be used without specific clinical indication.

   d. Daily supplementary iron 30-60 milligrams and folic acid 200-400 micrograms is necessary throughout the pregnancy.

   e. With proper diet other supplements are unnecessary.

   f. Smoking is not desirable.

8. All medications must be approved and recorded by the physician responsible for the obstetrical care. Diagnostic radiological studies are to be avoided unless urgent.

9. Prenatal Care Design —

   a. Individualized according to her needs.

   b. Patient must understand what is being done; what is planned and why.

   c. Danger symptom instructions should be given.

   d. Weight, blood pressure, urinalysis each visit.

   e. Record date of fetal motion and first audible fetal heartbeat.

   f. Compare and record uterine and fetal size each visit until delivery to determine compatibility or disparity of gestational age.

   g. Repeat hematocrit and hemoglobin studies at the beginning of the third trimester and on admission to labor section. Institute therapy if indicated.

   h. Antibody screening test must be repeated at 28-30 weeks on Rh-negative patients to insure that sensitization has not occurred.

   i. Assess fetal position, presentation, possibility of multiple pregnancy, hydramnious or aberrations of gross fetal development as term approaches.

   j. Hospitalize for investigation, consultation and treatment of all women with suspected or actual major complications of pregnancy.

   k. Discuss with patient what she should do at the onset of labor or premature rupture of membranes. Outline the program planned for labor, analgesia, anesthesia and delivery.

   l. Fetal maturity studies should be performed in patients with an uncertain due date before inductions or cesarean sections are performed.

   m. Diabetics and cardiorenal patients should be monitored with feto-placental function studies as a help in determining fetal well being.

   n. Contraceptive counseling should be offered to each patient which may include voluntary sterilization procedures.

Prepared for the Committee on Maternal and Perinatal Health, Michigan State Medical Society by Perry E. Prather, M.D., Saginaw, Michigan.

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Sodium benzoate (preservative)	60.0 mg
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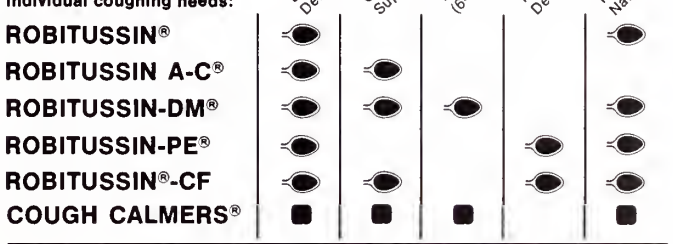

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Letters

Doctor Turner Calls For More Black Administrators

To the editor,

More than one year ago I, a black physician, decided to become a candidate for the Common Council of Detroit. This decision was made out of concern for my patients, my family and all people. I hoped to somehow focus attention on and bring to light many of the "inequities" in health care delivery.

I am writing now to voice again this concern as I feel the time is crucial, and that changes must be made and made by the "right" people. I definitely feel too, that many decisions have been made by "administrators" and people who are not as concerned or as familiar with the problems as those who deal on a day-to-day basis, in an intimate way with them.

There must be more blacks on the boards of trustees and executive committees of local hospitals. While there are many excellent foreign physicians we must not accept them and help them to the neglect of our own black aspirants to medical education. There is no doubt that one who has lived here all his life and speaks the language can relate to Americans better than someone who has not.

It is therefore at this time that we must insist on more "policy input" from those whose only input has been their money (medical insurance) and their lives, for the sake of better and more equitable health care delivery. I therefore urge that all citizens and organizations, especially our political, civic, and religious leaders, join with those concerned physicians who are *practicing* medicine, to bring about the aforementioned. It must be understood that in the past hospitals were "quasi-public" institutions as they were dominated policy-wise by the rich who made sizeable donations. This condition no longer exists for it is John Q. Public, through his taxes, who finances these institutions on a local, state and especially, federal level.

Yours truly,
Edward T. Turner, Jr., MD
Detroit

S, K & F Manager Notes Re-emphasis on National Health Insurance

John W. Moses, MD
Scientific Editor
Michigan Medicine

Dear Doctor Moses,

Listening to President Ford's recent address to Congress, I noticed his emphasis on the need for a health insurance bill this year. Following is an excerpt from his speech:

> "As Vice President, I have studied various proposals for better health-care financing. I saw them coming closer together, and urged my friends in Congress and in the Administration to sit down and sweat out a sound compromise. The comprehensive health insurance plan goes a long way toward providing early relief to people who are sick.
>
> Why don't we write — and I ask this with the greatest spirit of cooperation — why don't we write a good health bill on the statute books (in 1974) before this Congress adjourns?"

Prior to the President's remarks, a national health insurance bill was not given much chance of passage this year. Now, no one is so sure. I'm enclosing a reprint from the *National Health Insurance Resource Book* which summarizes the principle features of some of the major bills introduced in the Congress. As indicated in the enclosed article from the *Philadelphia Inquirer,* congressional leaders are apparently already considering a compromise bill.

The last reprint is from the July, 1974 issue of *Medical Group News* and discusses new legislation being considered by Senator Edward Kennedy in light of the recent Office of Technology Assessment report on the issue of bioequivalency.

I hope you will feel free to share the information contained in this letter with your colleagues and any comments from you would be appreciated.

Sincerely,

Edward F. X. Lawlor, Jr.
Manager, National Health Affairs
Smith, Kline & French Laboratories
Philadelphia

Copies of the articles referred to in Mr. Lawlor's letter are available at MSMS Headquarters.

In Memoriam

Herbert L. Fishbein, MD
Southfield

Herbert Leon Fishbein, MD, a radiologist for 20 years at Plymouth General Hospital in Detroit, died Sept. 23 in San Francisco. Doctor Fishbein, who was 54, was graduated from Chicago Medical School and had been affiliated also with Lakeside General and Columbia Medical Hospitals in Detroit.

Henry Kehoe, MD
Grosse Pointe Shores

The former medical director and chief of staff at Holy Cross Hospital, Detroit, Henry J. Kehoe, MD, died Sept. 28 at the age of 75. He was a member of the American Society of Internal Medicine and American College of Chest Physicians.

John M. Wellman, MD
Lansing

John M. Wellman, MD, executive secretary of the Michigan Medical Practice Board, died Sept. 29 at the age of 68. Doctor Wellman was a graduate of the University of Michigan Medical School. He had been former Michigan Blue Shield president and board member, president of the Ingham County Medical Society and an MSMS delegate for 11 years. He was chief of staff of Lansing's St. Lawrence Hospital and chief of surgery for Lansing's E. W. Sparrow Hospital. He was past president of the Michigan chapter, American College of Surgeons, past president of the Frederick A. Coller Surgical Society and member of the Central Surgical Association.

William H. Welch, MD
formerly of Lansing

William H. Welch, MD, 83, Lansing physician and surgeon for many years, died Sept. 24 in Sapulpa, Okla. A graduate of Northwestern University medical school, he practiced in Lansing from 1920 to 1943. He was affiliated with the E. W. Sparrow and St. Lawrence hospitals there. Following retirement, he made his home in Ann Arbor, then Ft. Lauderdale and then Sapulpa.

Fredrick F. Yonkman, MD
Holland

The former head of the Wayne State University Pharmacology Department and former president of the Ciba-Geigy Pharmaceutical Co., Fredrick F. Yonkman, MD, died Sept. 16 at the age of 72. Doctor Yonkman's research at Ciba led to the introduction of Serpasil, one of the earliest tranquilizers. Doctor Yonkman had taught at Columbia and Boston Universities, was affiliated with Massachusetts Memorial Hospital in Boston and Mt. Carmel Mercy Hospital in Detroit. Doctor Yonkman was vice president of the Northern Tri-State Medical Society and a member of the American Society for Pharmacology and Experimental Therapeutics and the Association of University Professors.

Monthly Surveillance Report

Cases of Certain Diseases
Reported to the Michigan Department of Public Health
For the Four-Week Period Ending September 27, 1974

	1974 This 4-Week Period	1973 Same 4-Week Period	1974 Total To Above Date	1973 Total Same Date	Total Cases for 1973
Rubella	35	26	1,211	1,849	2,001
Cong. Rubella Syndrome	0	0	0	1	4
Measles	46	25	1,950	4,378	4,552
Whooping Cough	14	11	75	58	86
Diphtheria	0	0	0	0	0
Mumps	80	59	5,461	3,952	5,042
Scarlet Fever & Strep Sore Throat	730	915	26,415	16,200	24,467
Tetanus	0	0	3	1	2
Poliomyelitis (paralytic)	0	0	1	0	0
Hepatitis	300	289	2,787	2,895	3,872
Salmonellosis (other than S. typhi)	86	82	785	544	795
Typhoid Fever (S. typhi)	1	2	7	10	14
Shigellosis	153	41	1,047	448	623
Aseptic Meningitis	24	81	111	314	434
Encephalitis	8	14	51	129	163
Meningococcic Meningitis	4	2	39	41	54
H. Influenza Meningitis	8	1	91	71	89
Tuberculosis	147	108	1,098	1,189	1,380
Syphilis	206	296	2,102	3,218	4,328
Gonorrhea	2,838	2,712	23,773	22,459	31,128

Information can be supplied by the local health department on the local incidence of disease.

MICHIGAN DEPARTMENT OF PUBLIC HEALTH

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"Through rain or snow . . ." the mail must (and does) go through even though it takes 31 years!

Actually Uncle Sam wasn't to blame at all for three letters recently returned to MSMS as undeliverable some 31 years after they were mailed.

Back in mid-January, 1943 an MSMS employee mailed a letter containing three payroll checks to Dr. L. Fernald Foster of Bay City for his signature as Secretary of MSMS. The letter was dropped in the mail slot of the doctor's office at 919 Washington in Bay City the next day and promptly disappeared for 31 years.

While remodeling the Bay City building this summer workmen discovered a sizeable number of letters in the front wall where they had apparently fallen due to faulty construction of the mail slot. The letter to Doctor Foster was returned to MSMS as undeliverable since the doctor is deceased.

The envelope bore the old MSMS address of 2020 Olds Tower, Lansing, a 3-cent "Victory" stamp and the familiar World War II slogan "Buy War Bonds and Save." Inside were the three unsigned payroll checks.

Of interest were the "Victory Tax Deductions" noted on the attached vouchers. How many readers remember paying "Victory Taxes?"

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Construction has begun on the new Mary Free Bed Hospital and Rehabilitation Complex in Grand Rapids. The facility will serve West Michigan and offer continued comprehensive multidisciplinary rehabilitation. Cost of the 80-bed hospital will be $5.5 million.

* * *

The new St. Joseph Mercy Hospital of Ann Arbor, under construction, has been boosted by a $600,000 donation from the Ford Motor Company's Ypsilanti-Rawsonville Community Relations Committee. The donation, made in August, is the hospital's largest building campaign gift to date.

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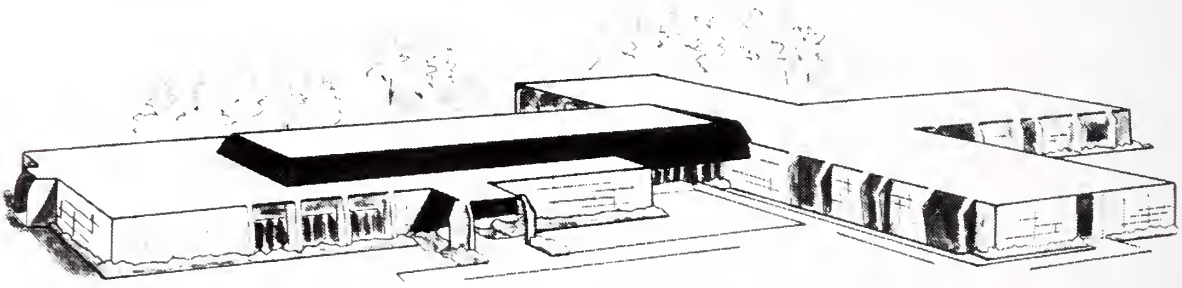

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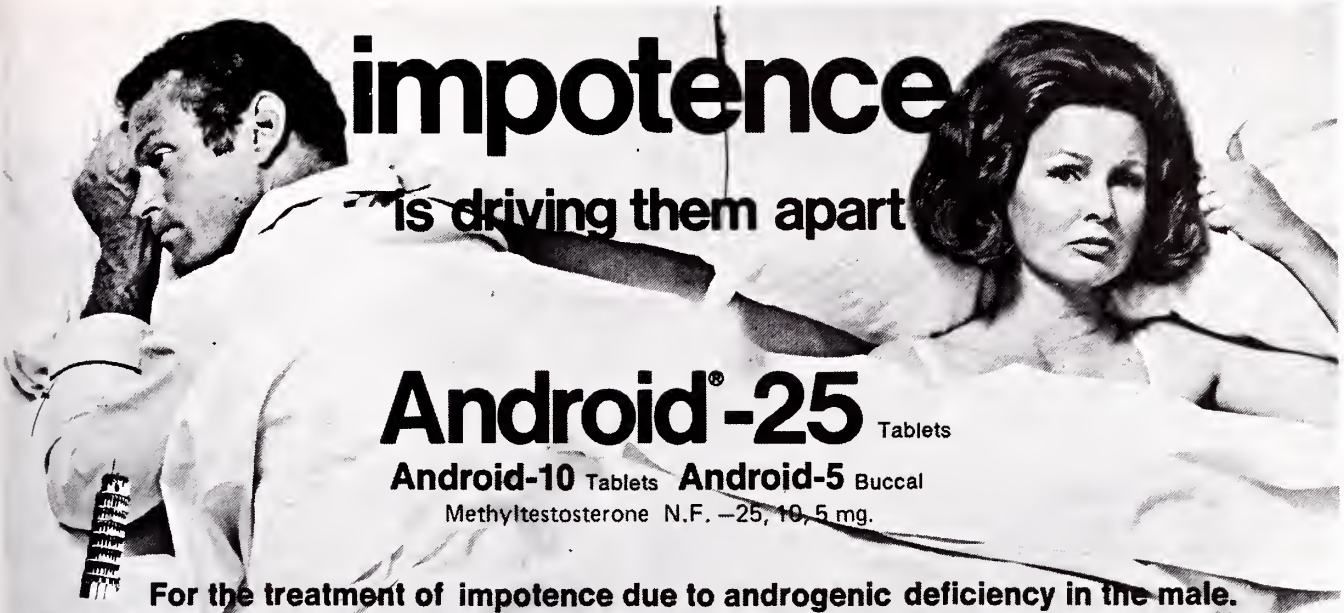

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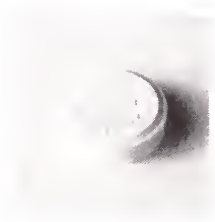
For further information on this subject, the following references are provided:

1. Henry BW, *et al: Dis Nerv Syst 30*:675-679, Oct 1969.
2. Hollister LE, *et al: Arch Gen Psychiatry 24*:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970.



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President's Page

Our 'Vital Mission'

Doctor Masters

These are extremely busy — and important — days for MSMS as efforts are continuing to develop a MSMS-sponsored professional liability insurance program for MSMS members. Work is moving forward also to seek changes in legislation and court procedures to permit doctors to provide full care for all the people of Michigan despite the worsening malpractice climate.

Please continue to read *Michigan Medicine* and the MSMS *Medigram* newsletter for developments.

During December and January . . .

1. MSMS Committee on Professional Liability and MSMS staff will try to complete negotiations with a major insurance carrier for the proposed sponsored insurance program.

2. MSMS Committee on State Legislation will draft several bills aimed at correcting various aspects of the malpractice problem and get them introduced hopefully for prompt consideration.

3. MSMS-State Bar Liaison Committee will continue to try to change court rules and procedures to rectify other problem areas.

4. MSMS Council and leaders of the Physicians Crisis Committee will seek new ways to move toward common goals.

5. MSMS Division on Public Service will fill requests for MSMS leaders to confer with radio, TV and newspaper reporters and editors.

6. MSMS Committee on Insurance Plans will help individual MDs obtain coverage.

7. MSMS Bureau of Economic Information will continue to conduct original research and to interpret economic information for MSMS, government, et al.

8. MSMS delegates to the AMA will continue to work with others to advance national action programs.

9. MSMS legal counsel will assist and advise re the drafting of state legislation and potential changes in court rules and regulations.

10. MSMS Department of Government will intensify productive contacts with Governor Milliken, Insurance Commissioner Demlow, and state officials and legislative leaders.

Meanwhile, it is essential that every MSMS member work to advance our unified, coordinated, positive efforts to resolve the malpractice situation on behalf of all our patients.

There is no question but that unity of the profession is of paramount importance in the forthcoming tribulations. Professional liability cannot be allowed to further threaten good medical care for everyone. It is entirely possible that our actions in this field might point the way to a resolution of the many liability problems throughout our culture. I appeal to you, Doctor, to contribute your expertise in this vital mission.

Brooker L. Masters, MD

No NHI Predicted Until 1978

By Herbert A. Auer, Manager
MSMS Department of Communications

It is unlikely the Congress will vote to enact any national health insurance until 1978.

That prediction was made by William Fullerton, senior staff executive for the powerful House Ways and Means Committee, at the Oakland County Medical Society meeting Nov. 6.

"There is no concensus now in the Ways and Means Committee for any national health insurance (NHI) approach," Mr. Fullerton said. "Chairman Mills does not intend to report any bill to the full House with any 13-12 or 11-10 margin of support."

Mr. Fullerton said the Democratic landslide Nov. 5 would have no effect on the NHI issue.

The factors that could lead to Congressional action before 1978 include the unemployment situation. "If unemployment increases and workers no longer have the protection of their health insurance coverage they then would agitate for a national program." Other contributing factors to earlier action, he said, included the rate of inflation in health care and the desires of President Ford.

"NHI will not be initiated in Congress in 1975 unless President Ford really insists."

Mr. Fullerton saw a timetable like this:

— The Ways and Means Committee will continue its research and consideration during 1975.

— NHI could become an election issue in 1976 depending upon presidential candidates.

— Approval for some form of NHI is not likely until 1978.

Mr. Fullerton said, "We will not have socialized medicine in the U.S.A. because the people do not want it."

"The Ways and Means Committee members are not interested in nationalizing doctors or hospitals. Fee for service will be retained and doctors will not be made employees of the government."

"I am confident that the AMA will revise its medicredit proposal and I see labor coming in with a new bill that will be more moderate than present proposals supported by labor."

When asked what a NHI package might contain, Mr. Fullerton reported there is little consensus now on any of the possible elements. "Four congressmen might agree on some of the elements, four others on something else, and a handful of congressmen on something else."

"There seems to be some general agreement that any NHI proposal should have such incentives as deductibles or co-insurance to retard overuse and abuse." Committee leaders also recognize, he said, that "When you fool around to create new demands for medical care, you must be concerned about medical manpower."

The question in Congress is not "if" the country will have NHI, but "when" and "what it will contain."

"Committee members are not looking at any health care programs in foreign countries, because they would not be relevant in the U.S.A.," Mr. Fullerton told the Oakland doctors.

The Ways and Means Committee is working now, he reported, to make some needed changes in the PSRO law. "The PSRO law was poorly written and improvements must be made," he said.

"The Committee is working closely with the AMA to be sure that doctors will make decisions about medical matters. Virtually all of the changes requested by the AMA will be accepted. PSRO will be made better for doctors."

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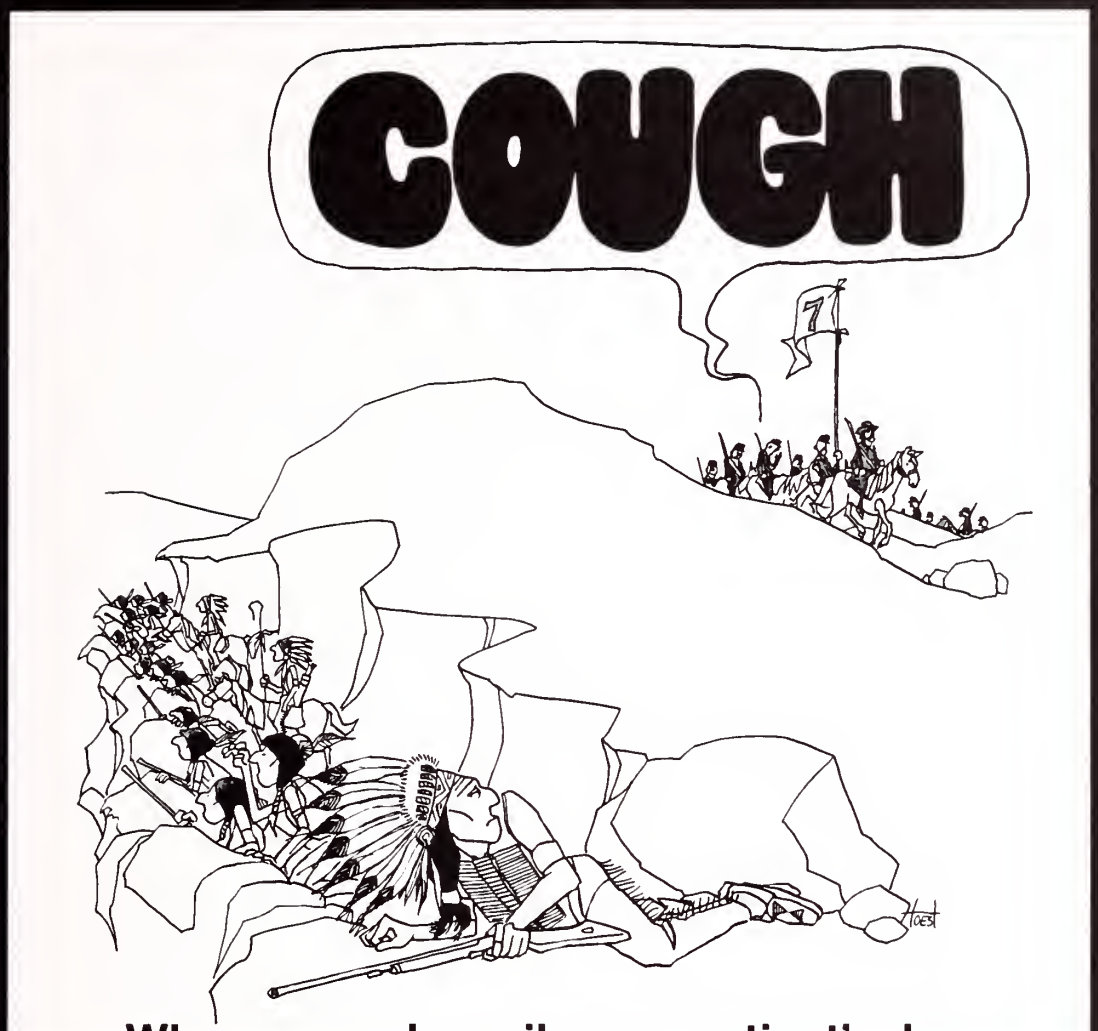

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Globoid-Cell Leukodystrophy:

Diagnosis and Management of Rare Clinical Disorders in the Community Hospital Setting

By Margaret Jones, MD; John Walker, BA, MS; Paul Jakubiac, MD; and Gerald Zick, MD, Lansing

Abstract

A case of early onset, rapidly progressive globoid cell leukodystrophy (Krabbe's leukodystrophy) is presented. The relevant history included a febrile course, rapid neurological deterioration and early death. The diagnosis of globoid cell leukodystrophy was substantiated by serum enzyme determinations and light and electron microscopy of a brain biopsy. These diagnostic procedures were completed while the patient remained in the community hospital where he was admitted because of the cooperative arrangements between primary physicians and resource consultants.

Introduction

Infantile globoid cell leukodystrophy (Krabbe's Disease) is a rapidly progressive, recessively inherited glycosphingolipidosis which clinically manifests in the first year of life with developmental and psychomotor retardation, spastic quadriplegia, pseudobulbar palsy, tonic seizures, generalized convulsions, cortical blindness or optic atrophy and deafness.[1,2,3]

In the typical patient, onset occurs between three and six months of age[2] and symptoms develop in three stages[4] over a clinical course averaging 10 to 12 months.[5,6] The clinical diagnosis is precisely established by the examination of galactocerebroside beta galactosidase activity of serum and leukocytes[7] as well as evaluation of brain and peripheral nerve specimens. Histopathological demyelination, astrocytic gliosis and globoid cell formation are most pronounced in the white matter.[8] Ultrapathological changes typically include myelin degeneration with or without axonal degeneration and irregular, polygonal or crystalloid cytoplasmic inclusions in the parenchymal and perivascular globoid cells.[3,9,10] However, definitive antemortem diagnosis is most reliably based on demonstration of a profound galactocerebroside beta galactosidase deficit as morphological variation is related to the stage of the disease and area of the brain biopsied.[2] Controversy has arisen, however, about the usefulness of urinary glycolipid analysis.

This case, an infant who presented at three months of age with a presumptive diagnosis of meningitis to the emergency room of a community hospital, is unusual because of the early onset and rapid clinical course. Furthermore, collaboration of the patient's physicians and efficient utilization of resource consultants permitted the diagnosis and management of this unusual case of Krabbe's leukodystrophy in the community hospital setting.

Report of a Case

The patient, a white male infant, was the product of an uneventful 40 week pregnancy and weighed 6 pounds 12 ounces at birth with 1 and 5 minute Apgar scores of 7 and 10 respectively. The immediate post natal period was uneventful. At approximately six weeks of age, the patient contracted a febrile illness coinciding in time with a local influenza epidemic. Subsequent throat culture was positive for the prevalent virus. At 13 weeks of age the patient, weighing 10 pounds 13½ ounces, was admitted to the hospital with fever, anorexia, apparent dysphagia, intermittent vomiting, meningismus and rigid extremities. The patient's developmental history had been unremarkable until four or five days prior to admission when the presenting symptom complex began to evolve. Relevant family history revealed the mother to be a gravida II, para I female who miscarried her first pregnancy at five months.

Physicial examination on admission revealed a well developed hyperirritable infant. The pa-

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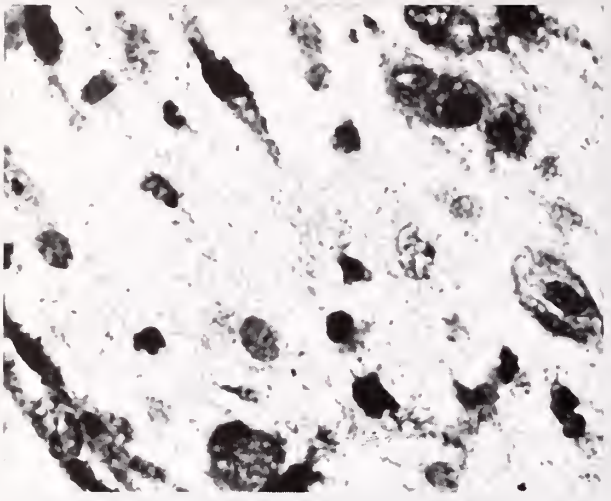

FIGURE 1: Section shows PAS positive mononuclear macrophages cells with foamy cytoplasm. LFB-PAS X 400

tient's head measured 41cm and the fontanelles were small and flat. A diffuse macular erythematous rash was present over the face, thorax and trunk. The patient would not track light and exhibited a sluggish pupillary response. Weak suck and bilateral Babinski reflexes were elicited. The nociceptor response was markedly sluggish. There was moderate resistance to passive movement of the neck and poor head control. The muscle mass was good and motor examination revealed hypertonicity in all extremities with three to four beats of delayed clonus at the ankles. The clear, colorless cerebrospinal fluid was found to have a protein fraction of 295mg percent without a concomitant increase in cell count.

The patient's condition consistently deteriorated during the 112-day hospital course which was characterized by periodic temperature elevations to 102.6F (rectal), cachexia and respiratory complications. Numerous throat cultures procured during the hospital course revealed E-coli and/or Klebsiella. Cerebro-spinal fluid protein ranged from 250 to 1000mg percent with a peak value of 1068mg percent recorded on hospital day five. An electroencephalogram and brain scan performed on the 11th day were inconclusive. However, evidence of progressive neurological deterioration was present from the 13th day when the patient failed to demonstrate visual or auditory function.

The patient developed vertical nystagmus and began to experience episodes of twitching and drooling on the 16th day. Occasional two minute tonic-clonic seizures were preceded or followed by mild opisthotonus. Pneumoencephalography accomplished on the 31st day revealed cortical atrophy and ventricular dilation.

Light and electron microscopic examination of a right frontal lobe biopsy on day 36 verified the clinical suspicion of Krabbe's disease. The diagnosis was confirmed by the absence of serum beta galactosidase.[7] The urinary glycolipid pattern was also found to be abnormal. Optic atrophy was noted on day 62; pupils were not reactive. Sporadic tonic-clonic convulsive activity continued with definite anisocoria.

From the 64th day the patient began to experience episodes of apnea and cyanosis. A constant fine tremor developed with stacatto twitching on stimulation. Periods of pulmonary congestion, cyanosis and respiratory distress increased in frequency and duration, eventually becoming refractory to deep tracheal suction and oxygen. As central nervous system symptoms became profound the patient became totally areflexive and unresponsive. During the week of the patient's demise the pulse was an irregular 180 while the respiratory rate rose to 66 and became labored. The patient expired on the 112th hospital day.

Light Microscopy

Special stains of glutaraldehyde and formalin-fixed paraffin embedded brain biopsy material included PAS, Luxol fast blue, Holmes, Nissl, trichrome and routine stains. Fresh frozen and glutaraldehyde fixed materials were stained for neutral fat with Oil Red O and for metachromasia with acidified cresyl violet stains. Glutaraldehyde fixed material was embedded in Epon, thick sectioned and stained with methylene blue. Thin sections of Epon embedded material were submitted for electron microscopic examination.

Examination of the routine and specially stained material revealed relative preservation of cortical neurons except in discrete areas. The molecular and outer granular layers of the cortex showed shrinkage of neurons. In the deeper layers, some shrinkage and occasional neuronophagic nodules were seen. The cortex in some areas was interrupted by the same pathology seen in the white matter. The meninges were not remarkable and no meningeal inflammatory infiltrate was seen. Neither perivascular lymphocytic cuffing nor discrete demyelination was seen in the adjacent cortex and white matter.

The most remarkable findings were seen in the white matter and consisted of diffuse demyelination with replacement of the normal cellular architecture with numbers of PAS positive macrophages *(Figure 1)*.

Although most of the macrophages occurred singly, some were clustered about small vessels, and in some areas multinucleate PAS positive globoid cells were present *(Figure 2)*. Globoid cells, both mononuclear and multinuclear, had large kidney shaped nuclei with a distinct nuc-

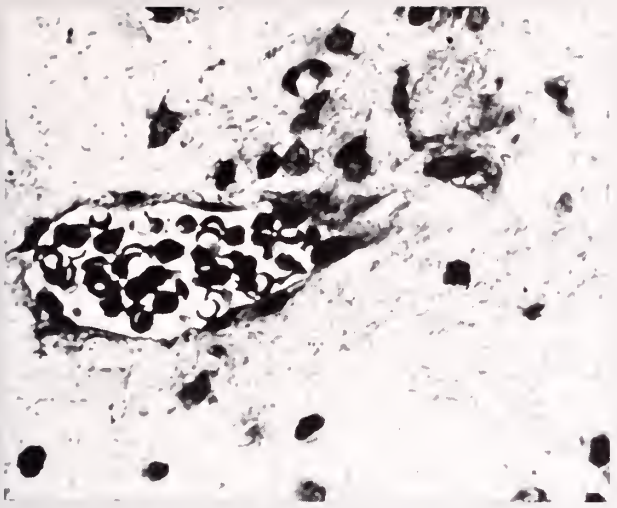

FIGURE 2: Foamy multinucleate globoid cells in a perivascular location are accompanied by increased numbers of astrocytes in the white matter. LFB-PAS X 400

lear membrane. The cytoplasm ranged from reticular to vacuolated to a somewhat homogeneous appearance. The cytoplasm was never so homogeneous as that seen in the gemistocytic astrocytes. Scattered between these cells were ill defined aggregates of basophillic material. A number of gemistocytic astrocytes were seen in the neuropil. In several areas these were predominant cells with macrophages being less abundant.

Electron Microscopy

Ultramicroscopic examination of prepared biopsy material revealed the characteristic findings reported for globoid cell leukodystrophy.[15,17,16,2,10]

Numerous astrocytic processes with abundant glial filaments *(Figure 3)* were present in the white matter. Several reactive hypertrophic astrocytes were observed to contain numerous lysosomes, spherically dilated endoplasmic cisterns, abundant polyribosomes, osmiophilic inclusions and peripherally displaced nuclei. Several electron dense microglia were also seen to have an enlarged cytoplasm. These cells contained numerous phagocytic vesicles, lysosomes and coarse granular bodies. Oligodendroglial cells were not identified in the material examined.

Few myelinated fibers were encountered. Although most myelin sheaths were not remarkable, occasional rarefaction, delamination, fragmentation and separation of the myelin sheath, with or without associated axonal degeneration, were noted.

Globoid-epithelial cells (G-E cells) were distinguished by their moderately granular ground substance, cytoplasmic pseudopods, abundant free ribosomes and aberrant intracytoplasmic inclusions *(Figure 4a & b)*. The inclusions were visualized as curvilinear tubular filaments of variable caliber and indeterminant length, demarked by an osmiophilic membrane and devoid of inter-

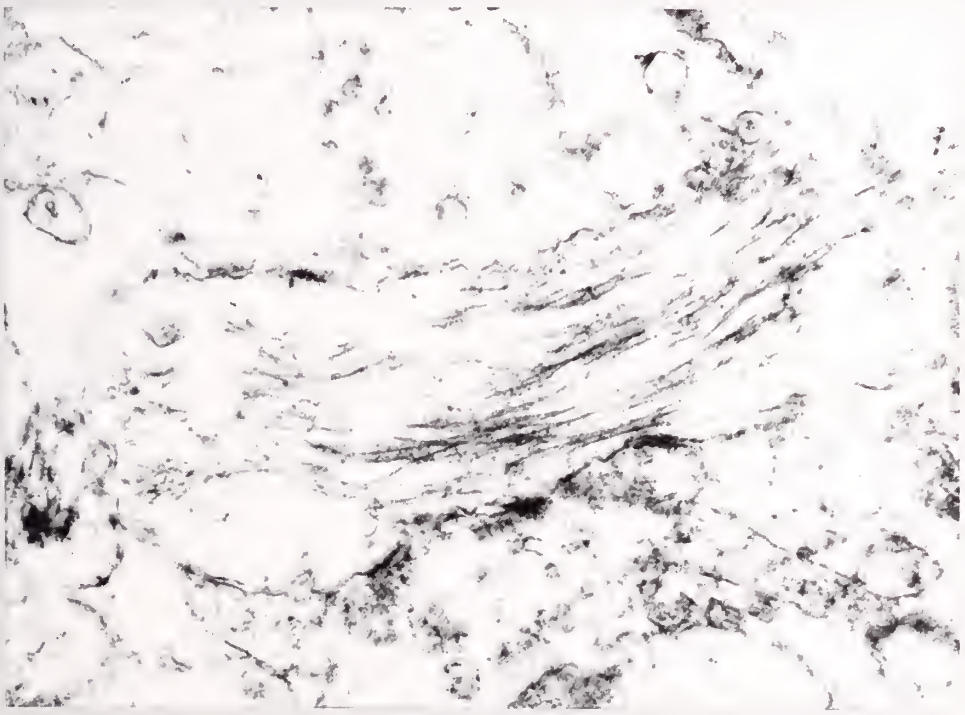

FIGURE 3: Process contains abundant glial filaments indicative of astrocytic proliferation X135,000

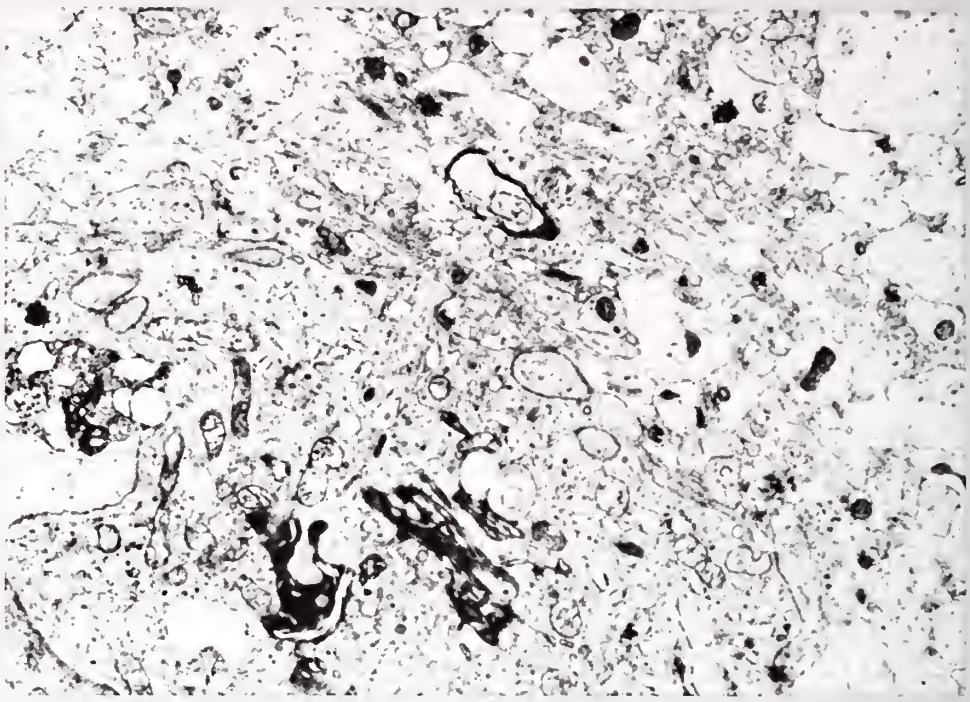

FIGURE 4A: Intracytoplasmic dense matrix surrounds curvilinear inclusions in Globoid cell cytoplasm X13,500

FIGURE 4B: Curvilinear tubular inclusions are surrounded by dense matrix X45,000

nal structure. The filaments were seen singly and in multiples through the G-E cell cytoplasm without apparent orientation or organelle association. Not infrequently the mitochondria of these cells were abnormally swollen and pleomorphic. These mitochondria lacked cristae and numerous angular inclusion — like formations were seen within their matrices. Endothelial and perithelial cells and numerous macrophages were not observed to contain similar cytoplasmic inclusions.

Serum Galactocerebroside Beta Galactosidase Activity

Serum samples from the patient, the patient's parents and controls were collected and frozen.

Table 1

	Galactocerebrosidase Activity (mumoles/hr/100 ml)
PATIENT	3.3
FATHER	7.1
MOTHER	18.7
CONTROL	30.7
CONTROL	37.4

Enzyme assays on serum samples from the patient and his parents demonstrated a relative absence of enzymatic activity in the patient and low activities in the parents compared to the two normal controls. Values reported for the parents are within the carrier range for this series. *(Assays courtesy of Kunihiko Suzuki, MD)*

The analysis was performed by Dr. Kunihiko Suzuki[7] and results showed markedly reduced activity with natural substrate in the patient, intermediary activity in the parents and normal activity in the control *(Table 1)*.

Urinary Glycolipids

The urine samples from the patient and a control were analyzed according to the method of Desnick et al[18] with the following modifications. In addition, the urinary supernatant was also dialyzed against water and extracted according to the method of Folch.[19] Thin layer and gas-liquid chromatography of the urinary sediment and authentic standards revealed an approximately two-fold increase in cerebroside which consisted of 77% glucosyl ceramide rather than the preponderance of galactosyl ceramide originally reported by Desnick et al.[11,13] There was no increase in urinary sediment dihexoside or trihexoside; however the tetrahexoside content of the urinary sediment was increased several times over reported normal values. Analysis of the supernatant from the urine of the patient and control revealed an approximate four-fold increase in cerebroside which was predominantly glucosyl ceramide, a seven-fold increase in dihexoside, a five-fold increase in trihexoside and a more than 30-fold increase in tetrahexoside *(Table 2)*. Identity and quantification of individual glycosphingolipids in both urinary supernatants and sediments was confirmed by gas-liquid chromatography according to the method of Vance and Sweeley.[20]

Discussion

Desnick et al have demonstrated the diagnostic usefulness of analysis of the urinary sediment in many glycosphingolipidoses.[11] While the method lacks the diagnostic precision of enzymatic analysis and the methodology is cumbersome, generally the urinary pattern of glycosphinogolipids does reflect the expected specific accumulations. However, the few reports of urinary glycolipids in Krabbe's disease[11,13] have not shown definite elevation of galactosyl ceramide. Furthermore, it has been demonstrated that kidney glucosyl ceramide increase parallels that of the galactosyl ceramide increase.[21] Thus, the exfoliated cellular elements from the kidney and urinary tract would not be expected to contribute an unusual proportion of galactosyl ceramide to the urinary sediment.[21] More recently Desnick has reported that urinary galactosyl ceramide is not elevated in Krabbe's disease.[13] Elevation of serum galactosyl ceramide has not been definitely demonstrated in Krabbe's disease either. It

Table 2
Urinary Glycolipids
(μm/24 hours)

Glycolipid	Urine Sediment Reported Values*	Urine Sediment Patient	Urine Supernatant Control	Urine Supernatant Patient
GL_1	.054	.104	.0562	.248
GL_2	.044	.027	.0296	.143
GL_3	.025	.0075	.0679	.326
GL_4	.020	.4744	.0243	.6801

Elevation of urinary cerebrosides (GL_1), both galactosyl and glucosyl ceramide was confirmed with the elevation mainly due to the presence of glucosyl ceramide. Generalized elevation of dihexosides (GL_2), trihexosides (GL_3) and tetrahexosides (GL_4) in both supernatant and sediment of patient's urine remains unexplained.

is not known whether the plasma cerebroside composition varies from the 10 to 15 percent content of galactosyl ceramide seen in patients with a variety of neurological and nonneurological diseases and controls.[23] Potentially, the serum cerebrosides could alter the urinary glycolipid pattern. There is no apparent explanation for the elevation of the remaining glycosphingolipids in the particular case, although generalized increases in glycosphingolipids in the presence of a single enzyme disorder have been reported in other organs. Similarly, in the analysis of other cases, generalized increases in both neutral lipids and phospholipids have been seen which had no apparent relationship to the presence of enzyme defects.

This observation remains unexplained. In addition, the paucity of urinary sediment and the relatively small amounts of glycosphingolipids in the urinary sediment compared to the urinary supernatant is also unexplained. However, glycosphingolipids or other lipid fractions of urinary superntants have not been previously quantified and reported for comparison.

Assays of the patient's serum for galactocerebroside beta galactocerebrosidase revealed a clear deficit in enzyme activity. This finding is expected as the patient is assumed to be homozygous for the autosomal recessive defect. Likewise, the parents, as obligate heterozygous carriers, therefore have lower enzyme activities than normally expected.[7] The mother's galactocerebroside beta galactocerebrosidase activity, although within the carrier range, was elevated. Such a variation might reflect the reported variability in penetrance and expressivity of the gene in question.[3]

The diagnosis based on the results of clinical evaluation and enzyme analysis was supported by light and electron microscopic examination of the surgical biopsy specimen. The observed histopathology and fine structure did not deviate in any significant manner from reported findings. This coincidence further substantiates the contention that definitive antemortem diagnosis of Krabbe's disease is reliably based on the biochemical examination of the patient's more readily available serum.

Perhaps the most interesting aspect of this case is the fact that the diagnosis and management of this patient with a rare and fatal leukodystrophy was accomplished within the community hospital setting. In this endeavor, a land-grant university department of pathology complemented efforts of community physicians by completing or obtaining diagnostic studies, genetic counseling and additional supportive services for the patient and his family without the added financial and emotional trauma of a distant referral. This extension service concept in total health-care delivery program provides for the efficient and convenient utilization, supplementation and augmentation of existing community expertise, facilities and services. The extension service concept is distinct from those of centralization and regionalization and merits serious consideration as an alternative to regional referral medical care.

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Biliary Fistula due to Anomalous Right Posterior Hepatic Duct

By Solomon K. Samuels, MD, Kalamazoo

Summary

The occurrence of aberrant biliary ducts in anatomical dissections is frequently encountered, however at surgery these ducts are rarely encountered; a case is presented of an anomalous biliary duct, the development of a biliary fistula, and its management is described.

The occurrence of biliary fistula following cholecystectomy is rare. However, transection of a hepatocystic duct or an accessory duct may result in biliary bile fistula, if the injury is unrecognized at the time of surgery. The incidence of accessory ducts has been reported to be as high as 15 per cent in some series.[1] However, clinically the injury to this duct is uncommon. When an injury occurs, it may be due to the fact that the anatomic relationship in the porta-hepatis is obscured by the inflammatory reaction, and when an anomalous duct is transected it may go unrecognized as the amount of bile flow during anesthesia is reduced.[2]

As early as 1866, Rex[3] and Melnikoff[4] studied intrahepatic ductal and vascular systems. They reported extensively on intra- and extrahepatic vascular systems, but not much was written about the occurrence of aberrant ducts. Hjortsjo[5] proposed for the first time, the concept of segmental drainage of the liver. In 1924, Flint[1] studied 200 consecutive specimens by the injection corrosion method and found 29 accessory ducts. He also reported that the typical textbook description of the ductal system, i.e., right and left hepatic duct uniting to form the common duct and the cystic duct uniting distal to this union, is only found in one-half the specimens.

The transection of an accessory posterior segmental duct that was unrecognized at the initial surgery, and the subsequent development of a biliary fistula and its management, is the subject of this paper.

Doctor Samuels is attending physician, Borgess Hospital and Bronson Methodist Hospital, Kalamazoo.

Fig. 1 Cholangiogram through cystic duct, showing normal right-left duct uniting to form common duct. There is no communication between the ductal systems.

Case History

M.S. is a 47-year-old female with a history of right upper quadrant and epigastric pain, nausea, and vomiting for about a year. She had a fatty food intolerance. The symptoms became more pronounced and more frequent the last six weeks. There was no history of alcoholic stools, jaundice, hematemesis, or malena.

The physical examination showed a rather obese female. The sclera were clear and the pupils were normal reacting to light. There was no cervical lymphadenopathy; the ear canals were clear; the drums were intact; the thyroid was of normal size, without any palpable masses. The chest was symmetrical. Lungs were clear to auscultation and percussion. Heart size was normal. The P.M.I. was in the fifth interspace. No mur-

Fig. 2 Fistulogram showing accessory posterior duct, with no communication with the main intrahepatical system.

murs were present. The abdomen was rotund. The liver, spleen, kidneys were not palpable. Murphy's sign was negative. Rectal and pelvic examinations were also negative.

The laboratory studies consisted of CBC, urine analysis, and a profile 12. Bilirubin and the alkaline phosphatase on the profile 12 were within the range of normal.

Diagnostic studies: An oral cholecystogram was done with the usual preparation. This showed a nonvisualizing gall bladder. A repeat study was then done with a double dose, with the same result. An intravenous cholangiogram was not performed. The patient then underwent cholecystectomy. There was much inflammatory reaction at the junction of the cystic to the common duct, but otherwise the surgery was unattended with any apparent complications. A Penrose drain was left near the foramen of Winslow.

Postoperatively the patient had the usual amount of drainage for the first three or four days. The drain was removed on the fifth postoperative day. She remained afebrile throughout. The patient continued to drain a moderate amount of bile from the drain site. This was thought to be a little unusual. However, the patient felt physically well and therefore she was sent home on the ninth postoperative day.

She was seen in the office about 20 days following surgery, at which time, she complained of an increasing amount of biliary drainage, together with muscle weakness and fatigue. She was seen again in three weeks. She continued to drain a copious amount of bile. She was readmitted to the hospital where a profile 12, CBC, bilirubin alkaline phosphatase were done and found to be within the range of normal. Electrolytes were normal. An intravenous cholangiogram was done, primarily to determine if there was any leakage from the extrahepatic biliary system. The intravenous cholangiogram showed a right hepatic, left hepatic duct uniting to form the common duct, and there did not appear to be any spillage of bile or biliary leak.

As her general condition continued to go downhill a second operation was undertaken. At the second operation she had about 500 cc's of bile in the abdomen. This was aspirated and the wound was irrigated. At the lower end of the gall bladder bed bile started to accumulate quite rapidly, and on further examination a duct could be identified which was found to be squirting small amounts of bile. This duct appeared to be at the right and posterior end of the porta-hepatis. Its size was approximately three to four mm. A small catheter was introduced into this and a cholangiogram was obtained. The cholangiogram showed a ductal structure with branches extending to the posterior and lower aspect of the right lobe; it appeared to drain the posterior segment of the right lobe of the liver. The cystic duct was found to be intact. The suture was removed from the cystic duct, a catheter was introduced and a cholangiogram was obtained. The cholangiogram showed a right hepatic, left hepatic duct uniting to form the common duct and the cystic duct uniting slightly distal to this. There was good flow of bile into the duodenum without any obstruction. There did not appear to be any communication between the accessory duct and the main extrahepatic biliary system. After evaluating the cholangiograms, and with much reluctance, the duct was ligated. The common duct was opened, a T tube was inserted and brought out through a stab wound.

The patient's postoperative course: The patient remained afebrile throughout. On the second day the intravenous fluid was discontinued and she was started on oral liquids. She was carefully observed for signs of obstructive jaundice. The eyes did not show any scleral icterus. The urine and stool remained normal color throughout the hospital course. About the fifth postoperative day the drain was removed. The sutures were removed on the eighth day and the patient was discharged. She returned to the office on the sixteenth day and an intravenous cholangiogram was per-

formed, which showed a normal extrahepatic biliary system. No leakage was found. The patient symptomatically did well. She was re-examined in a year and continues to remain anicteric and well.

Discussion

Drainage of the bile from cholecystectomy in small amounts is commonly observed. However, copious amounts of biliary drainage may indicate the following abnormalities:

1. Transection of large congenital Luschka[6] ducts. These ducts are found on the surface of the gall bladder. In the early stage of intrauterine development these ducts are large; they generally atrophy. Persistence of large fetal ducts may cause moderate amount of drainage following cholecystectomy.
2. The presence of a large hepatocystic duct which is not recognized at surgery.
3. The sloughing of the tie around the cystic duct.
4. The transection of an anomalous or accessory duct from either the right or the left lobe, unrecognized at the time of surgery.

Embryologically the gall bladder and the cystic duct develop from the caudal groove of the hepatic diverticulum. The liver and the hepatic ductal system develop from the ventral outgrowth of the ectodermal tube. At about five weeks development the cystic duct and the gall bladder are much larger than the hepatic diverticulum. They diminish in size as growth progresses, and communicating channels are established between the extrahepatic and the hepatic ductal system.

It is conceivable that at some point in the development failure or fusion or persistence of fetal ducts may result in either accessory or aberrant ducts. Luschka[6] described large surface ducts on the gall bladder in a small number of his sections. These ducts are in communication with the intrahepatic ductal system. Drainage from these ducts will cease spontaneously. The hepatovesical duct is another duct which is regularly found in fish and birds, and in some mammals, Quain.[7]

Neuhof,[2] described a patient with this anomaly. He reported a patient who had a large hepatocystic duct that required three operations. He treated this by drainage which ceased after several months. Since there is communication between this ductal system and the intrahepatic ducts, there is usually spontaneous closure of the fistula. Pollack,[8] reported a case of persistent fever and left upper quadrant pain following cholecystectomy; and at second operation 800 cc's of bile was found in the peritoneal cavity. Again a large cysto-hepatic duct was discovered. This was treated by drainage.

Moosman[9] reports an incidence of 15.2 per cent accessory ducts in their series. In addition to anomalies of the hepatic ducts, they described different patterns of union of the ducts. A most common anomaly is low union of the right and left hepatic duct, with the cystic duct entering the right hepatic duct. The second anomaly is the right posterior segmental duct entering the left hepatic duct. The third common anomaly is the union of the cystic duct to the distal common duct.

Healey and Schroy[10] in describing the pattern of drainage of the right lobe found that the right lobe was drained by two ducts — an anterior segmental duct which drained the anterior segment of the liver, and a posterior duct draining the posterior segment of the right lobe of the liver. The posterior lobe duct is usually the larger of the two. The posterior duct drained directly into the left hepatic duct in seven per cent of cases. The right posterior hepatic duct entered the main hepatic duct separately in 21 per cent of cases.

There is some confusion in the literature about terminology. By definition, accessory ducts are defined as "additional to" and therefore replacing ducts, the aberrant duct being described as the duct that is not a replacing but aberrant in location. However, Goldsmith and Woodburne[11] use the words interchangeably. It is their feeling that accessory and aberrant ducts do duplicate function of the major hepatic ductal system and therefore, being replacing ducts could be safely ligated.

The patient M.S. had a fairly large duct. It is unlikely that this is a hepatocystic duct as it does not communicate with the intrahepatic ductal system. Radiographically this duct appears to be an accessory duct. With much trepidation the therapy chosen in this case was ligation of the duct. The relatively benign course that followed would tend to support the impression that this is a replacing duct. The presence of an accessory duct such as this poses a serious problem in its management, as there is difficulty in ascertaining at the time of surgery whether this is a replacing duct. Whenever possible and if technically feasible anastomosis to the extrahepatic ductal system should be attempted. If this is not feasible a bypass procedure or drainage into the defunctionalized loop of bowel should be considered. Finally, ligation of the duct can be done if there is assurance that one is dealing with an accessory duct.

Conclusion

A patient is presented with an anomalous right posterior segmental duct which presumably drained into the cystic duct. Its treatment and the subsequent course is described.

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MICHIGAN DEPARTMENT OF PUBLIC HEALTH

Monthly Surveillance Report

Cases of Certain Diseases
Reported to the Michigan Department of Public Health
For the five-week period ending November 1, 1974

	1974 This 5-Week Period	1973 Same 5-Week Period	1974 Total To Above Date	1973 Total Same Date	Total Cases for 1973
Rubella	62	39	1,273	1,888	2,001
Cong. Rubella Syndrome	0	0	0	1	4
Measles	148	47	2,098	4,425	4,552
Whooping Cough	8	9	83	67	86
Diphtheria	0	0	0	0	0
Mumps	302	217	5,763	4,169	5,042
Scarlet Fever & Strep Sore Throat	1,552	2,233	27,967	18,433	24,467
Tetanus	0	0	3	1	2
Poliomyleitis (paralytic)	0	0	1	0	0
Hepatitis	350	372	3,137	3,267	3,872
Salmonellosis (other than S. typhi)	76	106	861	650	795
Typhoid Fever (S. typhi)	3	2	10	12	14
Shigellosis	157	67	1,204	515	623
Aseptic Meningitis	33	75	144	389	434
Encephalitis	4	19	55	148	163
Meningococcic Meningitis	5	3	44	44	54
H. Influenza Meningitis	11	6	102	77	89
Tuberculosis	135	101	1,233	1,290	1,380
Syphilis	214	417	2,316	3,635	4,328
Gonorrhea	3,247	3,670	27,020	26,129	31,128

Information can be supplied by the local health department on the local incidence of disease.

Maurice Reizen, M.D., Director
Michigan Department of Public Health

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MSMS President Brooker L. Masters, MD, right, checks flight plans with his pilot, before takeoff from the airport in Doctor Masters' hometown, Fremont. The pilot happens to be Doctor of Divinity Charles M. Lewis, of the First Congregational Church of Fremont and Doctor Masters' own pastor. Doctor Lewis also has been Doctor Masters' "sky pilot" for two years. The two have logged several thousand air miles together as Doctor Lewis has shuttled Doctor Masters to his many speaking engagements around the state.

Approximately 30 questions from the general public are answered by physicians on each segment of the new monthly program aired by Detroit's PBS-TV Channel 56. "Housecall" is moderated by Beverly Payne, Detroit television newswoman, right. Fielding the questions at the opening show Oct. 16 were, from left, Brock E. Brush, MD, Detroit, MSMS president-elect; Ethelene Crockett, MD, Detroit obstetrician-gynecologist, and Louis R. Zako, MD, Dearborn Heights family physician. The show is produced and sponsored by MSMS.

Over 150 questions are telephoned to Channel 56 studios during broadcasting of "Housecall." During the first show, they were received by medical assistants, aided by Jacqueline VanDeventer, standing left, MSMS staff assistant for medical assistants, and far right, Thomas Payne, MD, Lansing, chairman, MSMS Public Service Committee. Future "Housecall" programs are scheduled Dec. 18, Jan. 15 and Feb. 12.

MSMS Action

MSMS Council OKs Recommendations For Blues Merger

The MSMS Council is recommending to the MSMS House of Delegates that MSMS re-establish its prerogative to nominate the MD members of the Blue Shield corporate body. Following reorganization of Blue Shield in 1970 MSMS was represented in the corporate body, but most physician members were independent.

In addition, The Council has approved a statement of principles to be accepted in advance before MSMS supports consolidation of Blue Cross and Blue Shield. The principles were drawn up by the MSMS Committee to Study Consolidation of Blue Cross/Blue Shield, which recommended that MSMS should view the consolidation from the standpoint of how it would affect physicians.

Among these principles are:

1. That MSMS be given the prerogative of nominating members to the MD component of the new corporate body and that physician members of the board constitute at least the same proportion as the present Blue Shield Board.
2. That the present per case participation be continued.
3. That there be a board-level medical advisory committee composed of physician members of the new board of directors.
4. That physician membership on the board constitute at least one-third of the executive committee exclusive of ex officio members.
5. That a new uniform claim form, as recommended by MSMS, be adopted and implemented.
6. That the MSMS Council be the final arbitrator for conflicts involving physicians, and third parties or patients.
7. That the UCR program be administered in a fair manner so that reasonable is defined as paying charges *in full* for the 90th percentile of services rendered.
8. That the UCR program for Medicare be administered in the same way as regular business.
9. That there be movement towards a more comprehensive benefit structure that includes preventive services, especially immunization for children, prenatal care, payment of out-of-hospital surgery with allowances for a facility charge.

Maternal Health Committee Produces Notebook, Slide-tape Shows

The suggestions developed by the MSMS Committee on Maternal Health about good maternal medical care practices have been reprinted by MSMS from the desk reference cards onto pages for a looseleaf notebook — and these are available now to interested MSMS members. Members interested in a set of the pages or further information should write to Helen Schulte, MSMS, 120 West Saginaw, East Lansing 48823.

In addition, the committee has provided the impetus for production of a three-program series of synchronized slide-tape presentations on high risk pregnancy. Entitled "The High Risk Obstetric Patient," "Antenatal Management of the High Risk Obstetric Patient," and "The Detection of Fetal Distress in Labor," the programs were produced under a grant from the Michigan Department of Public Health and by the University of Michigan. Copies are available on loan from the Michigan Bureau of Maternal and Child Health. Members of the MSMS Committee also will serve as speakers and present the slides and tapes at meetings in their areas.

AMA Official Praises MSMS Effort

To the editor,

Herb Auer and Guy Beaumont, Jr. (AMA field representative for Michigan) have provided me with extensive information regarding the efforts your society is making to build membership. This letter is simply to congratulate you, your staff, and your leadership for your exceptional awareness regarding the membership issue, and for designing, without question, the finest program outline ever seen to this point in time.

Please be assured of our fullest cooperation.

David B. Weihaupt
AMA Public Affairs Division

MEETINGS

Jan. 22–MSMS Council, MSMS Headquarters, contact: Warren F. Tryloff, director.

Feb. 3-7–American College of Physicians postgraduate course on current concepts in oncology, cosponsored by U-M Medical Center, at Towsley Center, Ann Arbor, contact: ACP, 4200 Pine St., Philadelphia 19104.

Feb. 12–Obstetrical and Gynecological Medical Symposium, sponsored by Lansing Ob-Gyn Society, Michigan Society of Obstetricians and Gynecologists, E. W. Sparrow Hospital, MSU College of Human Medicine and Continuing Education Service, at Kellogg Center, East Lansing, contact: Thomas Kirschbaum, MD, 178 Giltner Hall, MSU, East Lansing 48823.

Feb. 18-20–Postgraduate course in EKG diagnosis, U-M Medical Center, Ann Arbor.*

Feb. 20-22–Otorhinolaryngology conference, U-M Medical Center, Ann Arbor.*

Feb. 21-22–Feb. 25-28–Postgraduate course in emergency medicine, U-M Medical Center, Ann Arbor.*

March 5-6–Postgraduate course in advances in pediatrics, U-M Medical Center, Ann Arbor.

March 10-11–Postgraduate course on surgical complications, prevention and management, U-M Medical Center, Ann Arbor.

March 12–The Council, MSMS Headquarters, contact: Warren F. Tryloff, director.

March 14-15–Tenth Annual Michigan Conference on the Medical Aspects of Organized Athletics, to be held in conjunction with the Great Lakes Athletic Trainers Association's annual meeting, Ann Arbor Inn, contact: Helen Schulte, MSMS Headquarters.

March 18-20 – Postgraduate course in morphology of the blood and marrow, U-M Medical Center, Ann Arbor.*

March 26-27–1975 Annual Michigan Conference on Maternal and Perinatal Health, Civic Auditorium and Pantlind Hotel, Grand Rapids, contact: Helen Schulte, MSMS Headquarters.

March 31-April 2–OB-Gyn conference, U-M Medical Center, Ann Arbor.*

April 16–Postgraduate course on orthopedics in family practice, U-M Medical Center, Ann Arbor.*

April 17-18–Course on medical technology/hematology, U-M Medical Center, Ann Arbor.*

April 21-25–American College of Physicians postgraduate course on recent progress in clinical endocrinology, co-sponsored by U-M Medical Center, at Towsley Center, Ann Arbor, contact: ACP, 4200 Pine St., Philadelphia 19104.

April 24-25–International conference on andrology, "The Human Semen and Fertility Regulation in the Male," at Wayne State University School of Medicine, contact: E. S. E. Hafez, PhD, WSU School of Medicine, 550 E. Canfield, Detroit, 48201.

April 24-26–Meeting of the Midwestern Association of Plastic Surgeons, Shiawassee Hotel, Southfield, contact: Burns Newby, MD, 20905 Greenfield, Southfield 48075.

April 27-29–Sixth Annual Scientific Conference of National Council on Alcoholism, Milwaukee, contact: Walter J. Murphy, National Council on Alcoholism, Suite 1720, 2 Park Ave., New York 10016.

May 1-2–Ophthalmology conference, U-M Medical Center, Ann Arbor.*

May 4–The Council, MSMS Headquarters, contact: Warren Tryloff, director.

May 4-6 – MSMS House of Delegates, Michigan Inn, Southfield, contact: Richard Campau, MSMS Headquarters.

May 13-14–Postgraduate course in therapeutics, U-M Medical Center, Ann Arbor.*

June 3-6–Postgraduate course in advances in internal medicine, U-M Medical Center, Ann Arbor.*

June 11–The Council, MSMS Headquarters, contact: Warren Tryloff, director.

June 15-19–AMA Annual Convention, Atlantic City.

June 23-27–Northern Michigan summer postgraduate education course for physicians, sponsored by the U-M Medical Center, at Shanty Creek Lodge, Bellaire.*

*Contact Robert K. Richards, Towsley Center, University of Michigan, Ann Arbor 48104.

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By John Ylvisaker, MD
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The Michigan Foundation for Medical and Health Education provides a way for Michigan physicians to demonstrate their concern and willingness to help meet the financial needs of medical and health education and to take an active role in the direction and control of medical education.

The December 6 *Medigram* is devoted to a description and explanation of the Michigan Foundation for Medical and Health Education, which relies on private donations.

For 30 years, the Foundation annually has made significant but necessarily small, contributions to worthy recipients including the Michigan Health Council, medical students and the three Michigan medical schools. The funds of the Foundation are in the magnitude of $300,000-400,000 but have remained relatively the same for years as there have been no additional sources of income.

The Foundation membership consists almost exclusively of MSMS Council members plus elected members of the Foundation Board of Trustees, almost all with strong MSMS affiliations. The Foundation is totally Michigan-oriented in its purposes and activities and through its by-laws is a Michigan State Medical Society organization and responsibility.

To expand the financial base and, in turn, expand the worthwhile activities of the Foundation, an organized, annual drive for contributions is being initiated this month. The drive is authorized by the Foundation Board of Trustees and approved by the membership and by the MSMS Council.

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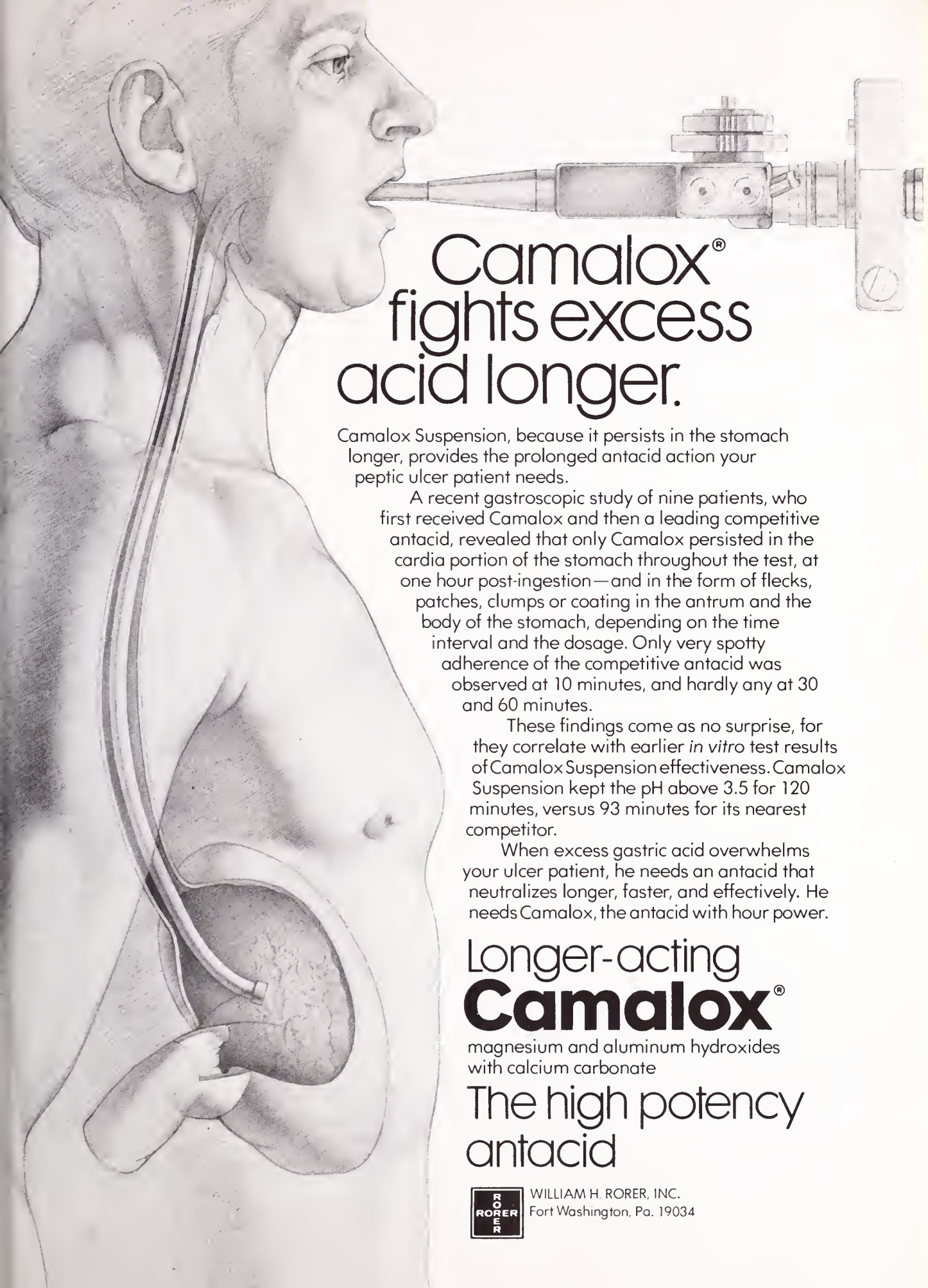

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Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

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(Continued on page 741)

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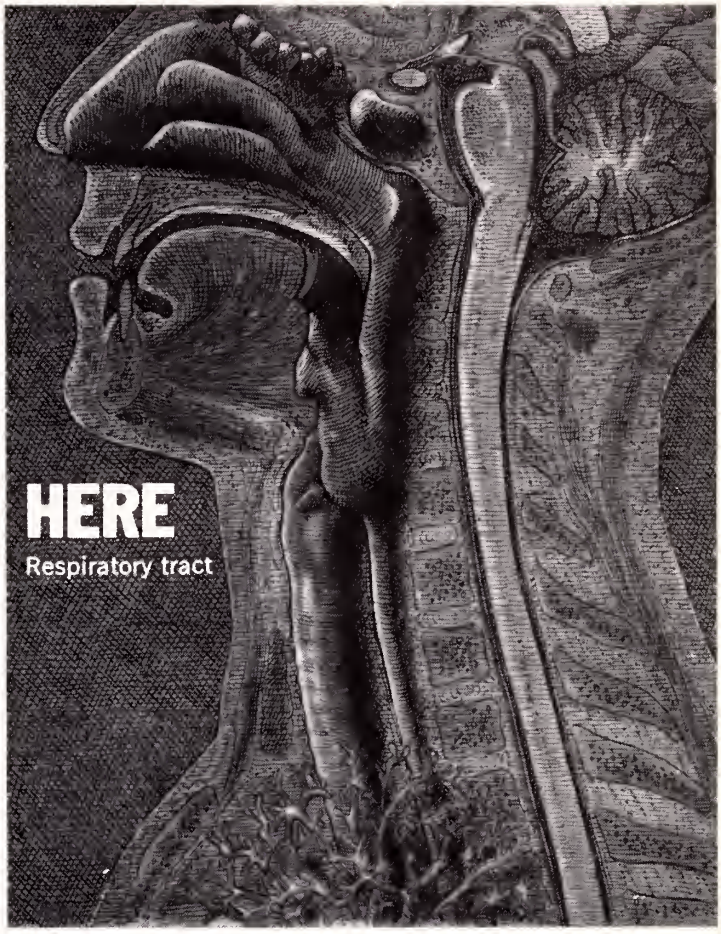

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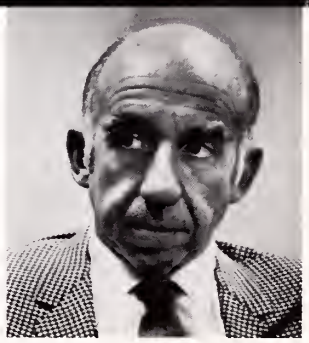

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The Positive Influence

My contact with representatives and salesmen of the pharmaceutical industry is the type of contact that people in a medical center, research people, and academic people have and that's in all likelihood on a somewhat different level from that of the practicing physician.

Let me touch on how I personally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be—and at times actually are—disseminators of useful information. They could consistently serve a real educational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets—some of it scientifically sound and therefore truly useful—as well as some excellent films produced by the pharmaceutical industry. When they function in this

Is He a Source of Information?

Yes, with certain reservations. The average sales representative has a great fund of information about the drug products he is responsible for. He is usually able to answer most questions fully and intelligently. He can also supply reprints of articles that contain a great deal of information. Here, too, I exercise some caution. I usually accept most of the statements and opinions that I find in the papers and studies which come from the larger teaching facilities. It goes without saying that a physician should also rely on other sources for his information on pharmacology.

Training of Sales Representatives

Ideally, a candidate for the position as a sales representative of a pharmaceutical company should be a graduate pharmacist who has a questioning mind. I don't think this is possible in every case, and so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

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capacity they are indeed useful; particularly in the fact that they disseminate broadly based educational material and serve not just as "pushers" of their drugs.

The Other Side of the Coin

Obviously, the pharmaceutical companies are not producing all this material as a labor of love—they are in the business of selling products for profit. In this regard the ambitious and improperly motivated sales representative can exert a negative influence on the practicing physician, both by presenting a one-sided picture of his product, and by encouraging the practitioner to depend too heavily on drugs for his total therapy. In these ways, the salesman has often distorted objective reality and undermined his potential role as an educator.

The Industry Responsibility

Since the detail man must be an information resource as well as a representative of his particular pharmaceutical company, he should be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.*, the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

P·M·A

In Memoriam

T. H. Edward Best, MD
Detroit

Long-time Detroit physician T. H. Edward Best, MD, died Oct. 17 at the age of 87. Doctor Best was a native of Ontario but had lived 74 years in the Detroit area. He was graduated from Detroit College of Medicine and was affiliated with Cottage Hospital, Grosse Pointe, East Side General and Anderson Memorial hospitals.

W. W. Bond, MD
Monroe

Monroe surgeon since 1927, William Webster Bond, MD, died Sept. 24 at the age of 75. Doctor Bond was a native of Winona, Miss., a graduate of the University of Tennessee Medical School and a veteran of both world wars. He twice was president of the Monroe County Medical Society and was a member of the American Association of Railway Surgeons. He was affiliated with Monroe and Mercy hospitals in Monroe.

Herman J. Carson, MD
Bloomfield Hills

Herman Jay Carson, MD, Detroit general practitioner, died Oct. 21 at the age of 63. Doctor Carson was a graduate of the Wayne State University School of Medicine and was on the staff of Northwest Grace Hospital. He was a member of the Maimonides Medical Society.

Gurdon S. Guile, MD
Flint

Flint generalist Gurdon S. Guile, MD, died Oct. 10 at the age of 68. He was a graduate of Hahnemann Medical School and was affiliated with Hurley, Saint Joseph and McLaren hospitals.

George D. Maniaci, MD
Gladstone

George D. Maniaci, MD, chairman of the Michigan Mental Health Advisory Council, died Oct. 10 in a motorcycle accident. He was 51. Doctor Maniaci practiced medicine in Gladstone since 1957 and was a member of the Michigan Association for Retarded Citizens. He was a member of the American Academy of Family Practice and was past president of the Delta Association for Retarded Children. He was a graduate of the Indiana University School of Medicine.

(Continued page 742)

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Doctor Coak's Clinic Serves Body and Soul

By Susan Berman
Special to Michigan Medicine

A new clinic in Adrian, the Christian Medical Mission, offers a unique combination of medical, emotional and spiritual care. Among the principal founders of the mission and now its director is Richard Coak, MD, a former Tecumseh general practitioner.

Volunteerism and donations from a broad spectrum of the community created the Christian Medical Mission and continue to be its entire support. Members of an interdenominational prayer group from the First United Presbyterian Church were among the mission's first supporters. That church also donated financial help and the clinic's building, a small, one-story, defunct restaurant.

The Adrian Dominican Sisters offered significant financial support as well as Sister Loretta Mellon. Formerly a Detroit teacher, Sister Loretta now counsels the missions' patients with problems ranging from drug addiction to depression.

Doctor Coak is a member of the MSMS Public Relations Committee, one of whose major concerns has been to ensure that people who need a doctor can find one.

Doctor Coak long had suspected there are some persons overlooked in the health care delivery system, "borderline" people neither qualified for Medicare or Medicaid nor insured privately, yet who cannot afford medical care.

Doctor Coak also wanted to offer a counseling service, a "place to go for people who need help," whose physical problems may be bound up with emotional or spiritual ones. His convictions were shared by the Rev. William Winch. Together, they formed an ecumenical committee in July to further the project and a board of directors was appointed.

A local construction crew renovated the restaurant and merchants donated the building materials. A physician's widow gave the clinic her late husband's office equipment. Many community physicians have agreed to accept referrals and have donated drugs. Three dentists also joined the effort, providing free dental treatment for the Mission patients.

Doctor Coak, an anexthesiologist mornings at Emma Bixby Memorial Hospital, joins Sister Loretta weekday afternoons in running the Mission. Volunteers staff the mission.

Doctor Coak confers with Sister Loretta.

WELCOME/*Continued*

Floro D. Rosario, MD, 18800 Woodward, Detroit 48203
Mark S. Roth, MD, 15901 W. 9 Mile Rd. #520, Southfield 48075
Gregory A. Sandman, MD, 4500 Cascade Rd., S.E., Grand Rapids 49506
Fillipo Santoro, MD, 11885 E. 12 Mile Rd., Warren 48093
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Chi-Pang Wen, MD, 705 Cherry Lane, Apt. #202, East Lansing 48824
Jerry D. Westerfield, MD, 1575 Fifth Ave., #101, San Francisco, CA 94122
Harvey S. Wilks, MD, 1840 Wealthy St., S.E., Grand Rapids 49506
Lawrence J. Zgliniec, MD, 880 Woodward Ave. #107, Pontiac 48053
Jacob Zvirbulis, MD, 4432 Greenstown Dr., Orchard Lake 48033

Inga W. Kirby, MD
Flint

Long-time Flint physician Inga W. Kirby, MD, died Nov. 1 at the age of 88. She was a life member of the Genesee County Medical Society and had been in practice 53 years. Prior to beginning her Flint practice in 1940, she had been dean of women at Detroit College of Medicine and Surgery. She was graduated from the University of Western Ontario and was an obstetrician-gynecologist.

William N. Sims, MD
Mt. Clemens

Willian N. Sims, MD, former chief of staff at St. Joseph Hospital, Mt. Clemens, died Oct. 19 at the age of 50. Doctor Sims had practiced in Mt. Clemens since 1956. He was a graduate of the University of Western Ontario Medical School and sponsored and financed the construction of the Little School of San Lorenzo in de Albarradas, Mexico, to provide education for students outside the government education district. He had been a member of the MSMS Maternal Health Committee.

Cornetta G. Moen, MD
Grand Rapids

A life member of the Kent County Medical Society, Cornetta G. Moen, MD, died Oct. 17 at the age of 78. Doctor Moen was the first woman physician to intern at Butterworth Hospital and continued on the medical staff there until her retirement in 1969. She was born in Buffalo Center, Iowa and was graduated from the University of Iowa Medical School. Doctor Moen was an obstetrician.

Frederick A. Sherwood, MD
Flint

Frederick Albert Sherwood, MD, Flint obstetrician-gynecologist, died Oct. 13, at the age of 53. Doctor Sherwood was a graduate of Temple University Medical School and was affiliated with McLaren General, Hurley and St. Joseph hospitals in Flint.

John C. Volderauer, MD
Kalamazoo

Kalamazoo radiologist John Charles Volderauer, MD, died Oct. 9 at the age of 67. Doctor Volderauer had practiced from 1937 until his retirement in 1969 and had been chief of radiology at Bronson Hospital. He was a past president of the Kalamazoo Academy of Medicine, a fellow of the American College of Radiology, a member of the Radiological Society of North America and of the Detroit Roentgen Ray Society. He was a graduate of Indiana University medical school.

STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION

Statement required by the Act of October 23, 1962; Section 4369, Title 39 of the United States Code showing the Ownership, Management and Circulation of Michigan Medicine, published four times in January and three times in all other months, 37 issues, mailed at East Lansing, Michigan, and additional post offices in Ingham County for December 1, 1974.

1. The office of the publisher is located at 120 West Saginaw Street, East Lansing, Michigan 48823.

2. The general business office of the publisher is located at 120 West Saginaw Street, East Lansing, Michigan 48823.

3. The publisher is the Michigan State Medical Society. The scientific editor is John W. Moses, MD, Mt. Carmel Mercy Hospital, Detroit, Michigan 48235; The managing editor is Judith Marr, 120 West Saginaw Street, East Lansing, Michigan 48823; the executive editor is Herbert A. Auer, 120 West Saginaw Street, East Lansing, Michigan 48823.

4. The owner is the Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823.

5. The known bondholders, mortgagees and other security holders owning or holding 1 percent or more of total amount of bonds, mortgages, or other securities are: None.

6. A. The total number of copies printed averages 8300 per issue with a single issue nearest to filing date accounting for 8136 copies.

   B. Paid circulation:
   7814 subscriptions by mail, these being the active members of the Michigan State Medical Society and others who receive subscriptions.

   C. Sales to dealers, number none.
   D. Free distribution by mail carrier or other means: 322.
   E. Total number of copies distributed is 8136.

I certify that the statements made by me above are correct and complete.

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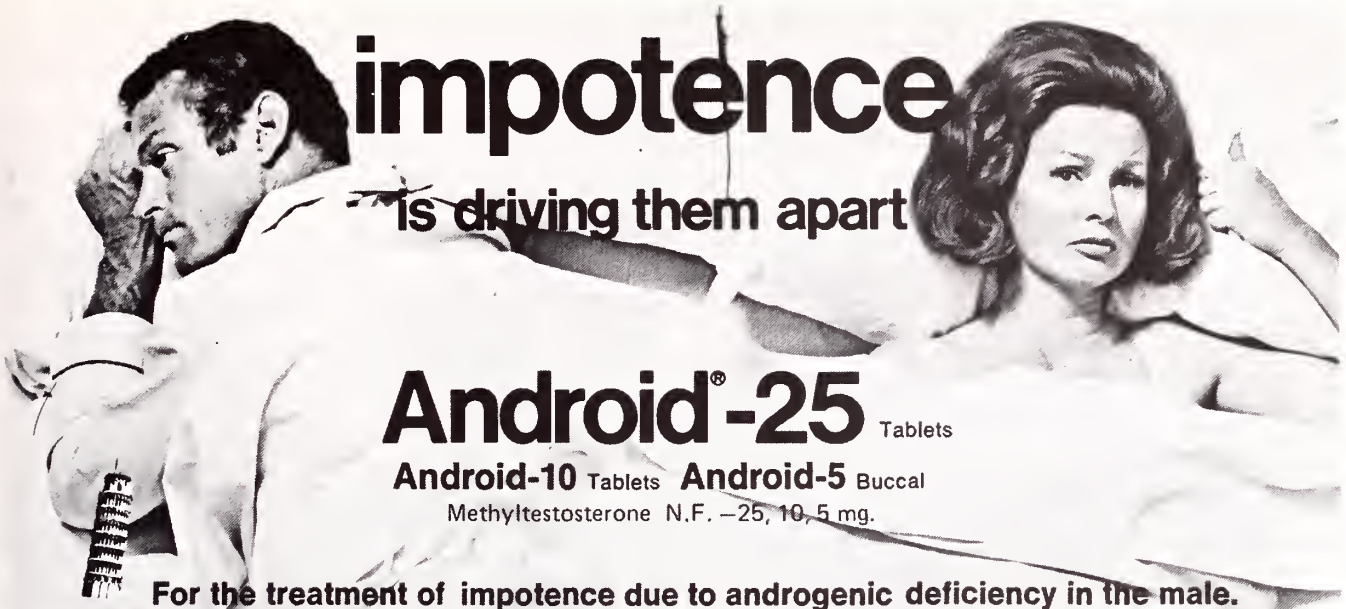

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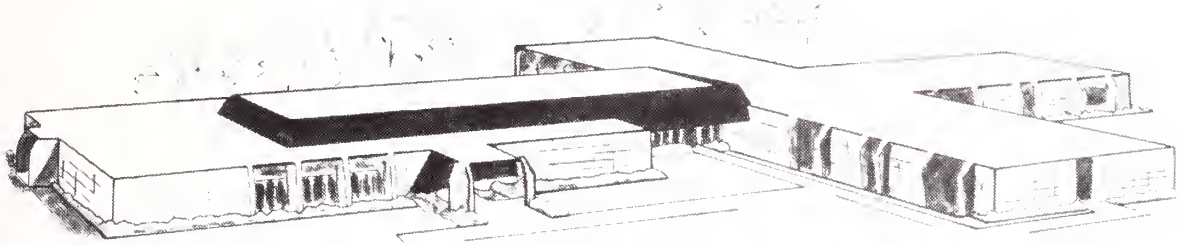

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Beating the Deadline

By Herbert A. Auer, Executive Editor

Loyal Jodar, MD, Grosse Pointe Shores, driving a Mustang, finished 22nd in the World Championship "Press on Regardless" Road Rally through the Upper Peninsula in November. No American car finished sooner than Doctor Jodar in the POR which was won by a Renault. Thirty-six of the 64 starting cars failed to finish.

* * *

H. Ross Hume, MD, a delegate for Wayne County Medical Society many years to the MSMS House, is now practicing in Petoskey. The orthopedic surgeon is located in the Lockwood-MacDonald Professional Building.

* * *

The busy chairman of the professional division of the Monroe United Way was **A. Esther Johnson, MD,** who recently retired from family practice.

* * *

"No fuss please," said **Edward A. Hier, MD,** when he completed 37 years at Alpena and 48 years as a physician. The Alpena General Hospital presented a plaque to the retiring doctor.

Hugh R. Allott, MD, Sault Ste. Marie, recently received a citation from the Upper Peninsula Areawide Comprehensive Health Planning Association for leadership as the chairman for two years.

* * *

The American Academy of Pediatrics television series on child health features **Frederick J. Margolis, MD,** Kalamazoo, the originator and producer for the series, being aired over 100 TV stations. The Kellogg Company underwrote the programs.

* * *

Mervyn Lakin, MD, Southfield, a member of the Oakland Community College Board of Trustees, made news recently when he advocated replacing tuition for residents with a modest property tax assessment.

* * *

Bruce Danto, MD, Detroit, has been appointed by Governor Milliken to the new "Commission for Volunteers in Michigan," named to promote volunteer activity in Michigan.

In a recent study, **Melvin L. Selzer, MD,** Ann Arbor, found that "a quarrel with your spouse or boss increases the chance of an auto accident about 25 per cent."

* * *

Golf, fishing and hunting will fill the hours now for recently-retired **Vernon C. Abbott, MD,** who has retired after 50 years of practice, and after 45 in Pontiac.

* * *

"Please send me one of the MSMS "Thank you for not smoking" signs to use in my new offices," wrote **Richard T. Allen, MD,** soon after he established his new practice in Las Vegas. A former member of the MSMS House of Delegates from the Muskegon County Medical Society, Doctor Allen is now at 901 Rancho Lane, Suite 206, Las Vegas 89106.

* * *

W.S.U. Medical student **Bernie Samet** is the new Michigan Handball Association open three-wall state singles champion. The Bronx native won the state tourney held in Detroit.

Doctor Hume

Doctor Johnson

Doctor Lakin

Doctor Abbott

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MICHIGAN/MEDICINE

OFFICIAL JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY

VOLUME 73, NUMBER 3 JANUARY, 1974

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Louis R. Zako, MD	1st	Dearborn Hgts.
Robert M. Stow, MD	2nd	Lansing
Robert M. Leitch, MD	3rd	Battle Creek
W. Kaye Locklin, MD	4th	Kalamazoo
Noyes L. Avery, Jr., MD	5th	Grand Rapids
Ernest P. Griffin, Jr., MD	6th	Flint
James H. Tisdel, MD	7th	Port Huron
William A. DeYoung, MD	8th	Saginaw
Adam C. McClay, MD	9th	Traverse City
Robert C. Prophater, MD	10th	Bay City
Leland E. Holly, II, MD	11th	Muskegon
Raymond L. Hockstad, MD	12th	Escanaba
Donald T. Anderson, MD	13th	Kingsford
Donato F. Sarapo, MD	14th	Adrian
Sydney Scher, MD	15th	Mt. Clemens
Paul T. Lahti, MD	15th	Royal Oak

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A. Stewart Kerr—Legal Counsel
John W. Moses, MD—Scientific Editor, *Michigan Medicine*

Michigan State Medical Society Directory

This directory contains an alphabetical listing of each member with his county society code number. The list below shows the code number for each county. The listing also indicates the special membership categories: "L" for Life Member; "M" for Military Members; "N" for Non-Resident Members; "R" for Retired Members; "A" for Associate Members; "O" for Osteopathic; "H" for Honorary. All others are Active Members. The directory lists those members as of Dec. 1, 1973.

EXAMPLE:		
John J. Smith, M.D.	102	(Kalamazoo County)
333 Cedar Street	R	(Retired Member)
Kalamazoo, Michigan	49007	(Zip Code)

Alcona County (Alpena-Alcona-Presque Isle) 014
Alger County (Marquette-Alger) 134
Allegan County 010
Alpena County (Alpena-Alcona-Presque Isle) 014
Antrim County (Northern Michigan) 170
Arenac County (Bay-Arenac-Iosco) 022

Baraga County (Houghton-Baraga-Keweenaw) 082
Barry County 018
Bay County (Bay-Arenac-Iosco) 022
Benzie County (Grand Traverse-Leelanau-Benzie) 070
Berrien County 026
Branch County 030

Calhoun County 034
Cass County 038
Charlevoix County (Northern Michigan) 170
Cheboygan County (Northern Michigan) 170
Chippewa County (Chippewa-Mackinac) 042
Clare County (Isabella-Clare) 096
Clinton County 046
Crawford County (North Central Counties) 150

Delta County (Delta-Schoolcraft) 050
Dickinson County (Dickinson-Iron) 054

Eaton County 058
Emmet County (Northern Michigan) 170

Genesee County 062
Gladwin County (North Central Counties) 150
Gogebic County 066
Grand Traverse County (Grand Traverse-Leelanau-Benzie) 070
Gratiot County 074

Hillsdale County 078
Houghton County (Houghton-Baraga-Keweenaw) 082
Huron County 086

Ingham County 090
Ionia County (Ionia-Montcalm) 094
Iosco County (Bay-Arenac-Iosco) 022
Iron County (Dickinson-Iron) 054
Isabella County (Isabella-Clare) 096

Jackson County 098

Kalamazoo County 102
Kalkaska County (North Central Counties) 150
Kent County 106
Keweenaw County (Houghton-Baraga-Keweenaw) 082

Lake County (Mecosta-Osceola-Lake) 142
Lapeer County 110
Leelanau County (Grand Traverse-Leelanau-Benzie) 070
Lenawee County 114
Livingston County 118
Luce County 122

Mackinac County (Chippewa-Mackinac) 042
Macomb County 126
Manistee County 130
Marquette County (Marquette-Alger) 134
Mason County 138
Mecosta County (Mecosta-Osceola-Lake) 142
Menominee County 146
Midland County 154
Missaukee County (Wexford-Missaukee) 226
Monroe County 158
Montcalm County (Ionia-Montcalm) 094
Montmorency County (North Central Counties) 150
Muskegon County 162

Newaygo County 166
North Central (Crawford, Gladwin, Kalkaska, Montmorency, Ogemaw, Oscoda, Otsego, Roscommon) 150

Oakland County 174
Oceana County 178
Ogemaw County (North Central Counties) 150
Ontonagon County 182
Osceola County (Mecosta-Osceola-Lake) 142
Oscoda County (North Central Counties) 150
Otsego County (North Central Counties) 150
Ottawa County 186

Presque Isle County (Alpena-Alcona-Presque Isle) 014

Roscommon County (North Central Counties) 150

Saginaw County 190
St. Clair County 194
St. Joseph County 198
Sanilac County 202
Schoolcraft County (Delta-Schoolcraft) 050
Shiawassee County 206

Tuscola County 210

Van Buren County 214

Washtenaw County 218
Wayne County 222
Wexford County (Wexford-Missaukee) 226

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Guide to Help Locate Cities within the Counties

This guide matches up the counties for Michigan communities containing doctors.

Ada (Kent)
Addison (Lenawee)
Adrian (Lenawee)
Albion (Calhoun)
Algonac (St. Clair)
Allegan (Allegan)
Allendale (Ottawa)
Allen Park (Wayne)
Alma (Gratiot)
Almont (Lapeer)
Alpena (Alpena)
Ann Arbor (Washtenaw)
August (Kalamazoo)

Bad Axe (Huron)
Baldwin (Lake)
Bangor (Van Buren)
Baraga (Baraga)
Bark River (Delta)
Battle Creek (Calhoun)
Bay City (Bay)
Bay View (Emmet)
Bear Lake (Manistee)
Belding (Ionia)
Bellaire (Antrim)
Belleville (Wayne)
Benton Harbor (Berrien)
Berkley (Oakland)
Berrien Center (Berrien)
Berrien Springs (Berrien)
Bessemer (Gogebic)
Beulah (Benzie)
Big Rapids (Mecosta)
Birch Run (Saginaw)
Birmingham (Oakland)
Blanchard (Isabella)
Blissfield (Lenawee)
Bloomfield Hills (Oakland)
Bloomingdale (Van Buren)
Boyne City (Charlevoix)
Branch (Mason)
Breckenridge (Gratiot)
Bridgeport (Saginaw)
Bridgman (Berrien)
Brighton (Livingston)
Bronson (Branch)
Brooklyn (Jackson)
Brown City (Sanilac)
Buchanan (Berrien)
Byron Center (Kent)

Cadillac (Wexford)
Caledonia (Kent)
Calumet (Houghton)
Camden (Hillsdale)
Capac (St. Clair)
Carleton (Monroe)
Caro (Tuscola)
Caseville (Huron)
Cass City (Tuscola)
Cassopolis (Cass)
Cedar Springs (Kent)
Center Line (Macomb)
Centreville (St. Joseph)
Champion (Marquette)
Charlevoix (Charlevoix)
Charlotte (Eaton)
Chassell (Houghton)
Cheboygan (Cheboygan)
Chelsea (Washtenaw)
Chesaning (Saginaw)
Clare (Clare)
Clarkston (Oakland)
Clawson (Oakland)
Clinton (Lenawee)
Clio (Genesee)
Coldwater (Branch)
Coleman (Midland)
Coloma (Berrien)
Colon (St. Joseph)
Columbiaville (Lapeer)
Concord (Jackson)
Constantine (St. Joseph)
Coopersville (Ottawa)
Corunna (Shiawassee)
Croswell (Sanilac)
Crystal Falls (Iron)
Custer (Mason)

Daggett (Menominee)
Davison (Genesee)
Dearborn (Wayne)
Dearborn Heights (Wayne)
Decatur (Van Buren)
Deckerville (Sanilac)
Deerfield (Lenawee)
Delton (Barry)
Detroit (Wayne)
Dewitt (Clinton)
Dexter (Washtenaw)
Douglas (Allegan)
Dowagiac (Cass)
Drayton Plains (Oakland)
Drummond Island (Chippewa)
Dundee (Monroe)
Durand (Shiawassee)

Eagle Harbor (Keweenaw)
East Detroit (Macomb)
East Jordan (Charlevoix)
East Lansing (Ingham)
East Tawas (Iosco)
Eaton Rapids (Eaton)
Ecorse (Wayne)
Edmore (Montcalm)
Edwardsburg (Cass)
Elk Rapids (Antrim)
Elkton (Huron)
Eloise (Wayne)
Elsie (Clinton)
Engadine (Mackinac)
Escanaba (Delta)
Essexville (Bay)
Evart (Osceola)

Fairgrove (Tuscola)
Farmington (Oakland)
Farwell (Clare)
Fennville (Allegan)
Fenton (Genesee)
Fenwick (Montcalm)
Ferndale (Oakland)
Flat Rock (Wayne)
Flint (Genesee)
Flushing (Genesee)
Fowlerville (Livingston)
Frandor (Ingham)
Frankenmuth (Saginaw)
Frankfort (Benzie)
Franklin (Oakland)
Fraser (Macomb)
Freeland (Saginaw)
Fremont (Newaygo)

Galesburg (Kalamazoo)
Garden City (Wayne)
Gaylord (Otsego)
Gladstone (Delta)
Gladwin (Gladwin)
Glen Arbor (Leelanau)
Gobles (Van Buren)
Goodrich (Genesee)
Grand Beach (Berrien)
Grand Blanc (Genesee)
Grand Haven (Ottawa)
Grand Ledge (Eaton)
Grand Marais (Alger)
Grand Rapids (Kent)
Grandville (Kent)
Grant (Newaygo)
Grayling (Crawford)
Greenville (Montcalm)
Grosse Ile (Wayne)
Gwinn (Marquette)

Hamburg (Livingston)
Hamilton (Allegan)
Hamtramck (Wayne)
Hancock (Houghton)
Hanover (Jackson)
Harbert (Berrien)
Harbor Beach (Huron)
Harbor Springs (Emmet)
Harper Woods (Wayne)
Harrison (Clare)
Harrisville (Alcona)
Harsens Island (St. Clair)
Hart (Oceana)
Hartford (Van Buren)
Haslett (Ingham)
Hastings (Barry)
Hazel Park (Oakland)
Hemlock (Saginaw)
Hessel (Mackinac)
Hickory Corners (Barry)
Highland (Oakland)
Highland Park (Wayne)
Hillsdale (Hillsdale)
Holland (Ottawa)
Holly (Oakland)
Holt (Ingham)
Homer (Calhoun)
Horton (Jackson)
Houghton (Houghton)
Howell (Livingston)
Hudson (Lenawee)
Hudsonville (Ottawa)
Huntington Woods (Oakland)

Imlay City (Lapeer)
Indian River (Cheboygan)
Inkster (Wayne)
Ionia (Ionia)
Iron Mountain (Dickinson)
Iron River (Iron)
Ironwood (Gogebic)
Ishpeming (Marquette)
Ithaca (Gratiot)

Jackson (Jackson)
Jamestown (Ottawa)
Jonesville (Hillsdale)

Kalamazoo (Kalamazoo)
Kalkaska (Kalkaska)
Keego Harbor (Oakland)
Kent City (Kent)
Kinde (Huron)
Kingsford (Dickinson)

Lake City (Missaukee)
Lakeland (Livingston)

Lake Odessa (Ionia)
Lake Orion (Oakland)
Lakeview (Montcalm)
Lambertville (Monroe)
L'Anse (Baraga)
Lansing (Ingham)
Lapeer (Lapeer)
La Salle (Monroe)
Lathrup Village (Oakland)
Laurium (Houghton)
Lawrence (Van Buren)
Lawton (Van Buren)
Leonidas (St. Joseph)
Leslie (Ingham)
Lincoln Park (Wayne)
Linden (Genesee)
Litchfield (Hillsdale)
Livonia (Wayne)
Lowell (Kent)
Ludington (Mason)
Luther (Lake)
Luzerne (Oscoda)

Mackinaw Island (Mackinac)
Madison Heights (Oakland)
Manchester (Washtenaw)
Manistee (Manistee)
Manistique (Schoolcraft)
Manitou Beach (Lenawee)
Marcellus (Cass)
Marine City (St. Clair)
Marion (Osceola)
Marlette (Sanilac)
Marquette (Marquette)
Marshall (Calhoun)
Martin (Allegan)
Marysville (St. Clair)
Mason (Ingham)
Mecosta (Mecosta)
Melvindale (Wayne)
Memphis (St. Clair)
Menominee (Menominee)
Merrill (Saginaw)
Metamora (Lapeer)
Michigan Center (Jackson)
Middleville (Barry)
Midland (Midland)
Milan (Washtenaw)
Milford (Oakland)
Millington (Tuscola)
Mio (Oscoda)
Monroe (Monroe)
Montague (Muskegon)
Montrose (Genesee)
Morenci (Lenawee)
Mount Clemens (Macomb)
Mount Morris (Genesee)
Mount Pleasant (Isabella)
Muir (Ionia)
Mullet Lake (Cheboygan)
Munising (Alger)
Muskegon (Muskegon)
Muskegon Heights (Muskegon)

Nashville (Barry)
Negaunee (Marquette)
Newaygo (Newaygo)
Newberry (Luce)
New Buffalo (Berrien)
New Era (Oceana)
New Port (Monroe)
Niles (Berrien)
North Branch (Lapeer)
North Muskegon (Muskegon)
Northport (Leelanau)
Northville (Wayne)
Norway (Dickinson)

Oak Park (Oakland)
Okemos (Ingham)
Olivet (Eaton)
Onaway (Presque Isle)
Onsted (Lenawee)
Ontonagon (Ontonagon)
Orchard Lake (Oakland)
Oscoda (Iosco)
Ossineke (Alpena)
Otisville (Genesee)
Otsego (Allegan)
Ovid (Clinton)
Owosso (Shiawassee)
Oxford (Oakland)

Parchment (Kalamazoo)
Parma (Jackson)
Paw Paw (Van Buren)
Pentwater (Oceana)
Petoskey (Emmet)
Pigeon (Huron)
Pinckney (Livingston)
Pinconning (Bay)
Plainwell (Allegan)
Pleasant Lake (Jackson)
Pleasant Ridge (Oakland)
Plymouth (Wayne)
Pontiac (Oakland)
Portage (Kalamazoo)
Port Huron (St. Clair)
Portland (Ionia)
Potterville (Eaton)
Prudenville (Roscommon)
Pullman (Allegan)

Quincy (Branch)

Reading (Hillsdale)
Reed City (Osceola)
Reese (Tuscola)
Remus (Mecosta)
Richland (Kalamazoo)
Richmond (Macomb)
River Rouge (Wayne)
Riverview (Wayne)
Rives Junction (Jackson)
Rochester (Oakland)
Rockford (Kent)
Rockwood (Wayne)
Rogers City (Presque Isle)
Romeo (Macomb)
Romulus (Wayne)
Roscommon (Roscommon)
Rosebush (Isabella)
Roseville (Macomb)
Royal Oak (Oakland)

Saginaw (Saginaw)
Sagola (Dickinson)
Saline (Washtenaw)
Sandusky (Sanilac)
Sanford (Midland)
Saranac (Ionia)
Saugatuck (Allegan)
Sault Sainte Marie (Chippewa)
Sawyer (Berrien)
Schoolcraft (Kalamazoo)
Scottville (Mason)
Sebewaing (Huron)
Shelby (Oceana)
Sidney (Montcalm)
Southfield (Oakland)
Southgate (Wayne)
South Haven (Van Buren)
South Lyon (Oakland)
Sparta (Kent)
Spring Lake (Ottawa)
Stambaugh (Iron)
Standish (Arenac)
Stanton (Montcalm)
St. Charles (Saginaw)
St. Clair (St. Clair)
St. Clair Shores (Macomb)
Stephenson (Menominee)
Sterling Heights (Macomb)
St. Ignace (Mackinac)
St. James (Charlevoix)
St. Johns (Clinton)
St. Joseph (Berrien)
St. Louis (Gratiot)
Stockbridge (Ingham)
Sturgis (St. Joseph)
Sunfield (Eaton)
Suttons Bay (Leelanau)
Swartz Creek (Genesee)

Tawas City (Iosco)
Taylor (Wayne)
Tecumseh (Lenawee)
Temperance (Monroe)
Three Rivers (St. Joseph)
Traverse City (Grand Traverse)
Trenton (Wayne)
Troy (Oakland)
Trufant (Montcalm)

Ubly (Huron)
Union City (Branch)
Union Lake (Oakland)
Utica (Macomb)

Vandalia (Cass)
Vassar (Tuscola)
Vicksburg (Kalamazoo)
Vulcan (Dickinson)

Wakefield (Gogebic)
Walkerville (Oceana)
Walled Lake (Oakland)
Warren (Macomb)
Waterford (Oakland)
Watervliet (Berrien)
Wayland (Allegan)
Wayne (Wayne)
Weidman (Isabella)
Wellston (Manistee)
West Branch (Ogemaw)
Westland (Wayne)
Westphalia (Clinton)
White Cloud (Newaygo)
Whitehall (Muskegon)
White Pigeon (St. Joseph)
White Pine (Ontonagon)
Whitmore Lake (Washtenaw)
Williamston (Ingham)
Wixom (Oakland)
Wyandotte (Wayne)
Wyoming (Kent)

Yale (St. Clair)
Ypsilanti (Washtenaw)

Zeeland (Ottawa)

ALPHABETICAL LISTING OF MSMS MEMBERS

This directory contains an alphabetical listing of each member with his county society code number on the same line as his name. The list of counties with the code numbers is on page 1.

EXAMPLE:

John J. Smith, M.D.	102	(Kalamazoo County)
333 Cedar Street	R	(Retired Member)
Kalamazoo, Michigan	49007	(Zip Code)

A

HUGO A AACH MD 102
425 SORRENTO CT R
PUNTA GORDA FL 33950

AUSTIN A AAROEMA MD 162
1470 PECK ST
MUSKEGON MICHIGAN 49441

ADNAN ABBASI MD 174
WM BEAUMONT HOSPITAL A
ROYAL OAK MI 48072

ALI A ABBASI MD 222
1211 ELMWOOD W
CLAWSON MI 48017

A ABBASSIAN MD 222
30900 FORD RD
GARDEN CITY MI 48135

JAMES A ABBOTT MD 222
VA HOSPITAL
ALLEN PARK MI 48101

R RODERIC ABBUTT MD 062
G-1071 N BALLENGER
FLINT MI 48504

VERNON C ABBOTT MD 174
1405 PONTIAC ST BK L
PONTIAC MI 48058

MARTIN M ABBRECHT MD 174
800 S ADAMS RD
BIRMINGHAM MI 48011

GERALD J ABEN MD 222
15901 W 9 MILE RD
SOUTHFIELD MI 48075

ARSENIO B ABLAO MD 106
1330 BRADFORD ST NE
GRAND RAPIDS MI 49503

ELIE D ABOULAFIA MD 222
18241 GREENFIELD
DETROIT MI 48235

A O ABRAHAM MD 114
327 W MAIN ST
HUDSON MI 49247

JOS P ABRAHAM MD 222
2799 W GRAND BLVD
DETROIT MI 48202

SAMUEL M ABRAMSON MD 222
15041 E SEVEN MILE RD
DETROIT MI 48205

ANTHONY M ABRUZZO MD 110
1568 RULANE DR
LAPEER MI 48446

MICHEL A ABSI MD 126
28043 HOOVER RD
WARREN MI 48093

ROMULO T ABUEVA MD 102
1521 GULL RD
KALAMAZOO MI 49001

C N ACHARYA MD 106
200 JEFFERSON AVE SE
GRAND RAPIDS MI 49503

GERALD L ACKERMAN MD 190
4700 PINE HAVEN DR R
SAGINAW MICH 48603

H R ACKERMAN JR MD 174
909 WOODWARD AVE #104
PONTIAC MI 48053

JOHN R ACKERMANN MO 090
73 MARTINIQUE
TAMPA FL 33606

JAMES R ACOCKS MD 134
MORGAN HEIGHTS
MARQUETTE MICH 49855

JULIO B ACOSTA MD 222
27634 FIVE MILE RD
LIVONIA MI 48154

ROBIN ADAIR MD 174
6405 TELEGRAPH RD
BIRMINGHAM MI 48010

GERALD D ADAMIAN MD 222
15901 W 9 MILE RD
SOUTHFIELD MI 48075

ALBERT C ADAMS MD 062
5210 LAPEER RD
FLINT MI 48503

BURNELL H ADAMS MO 062
609 S LYNCH ST
FLINT MI 48503

CHARLES ADAMS MD 090
2909 E GRAND RIVER
LANSING MICHIGAN 48912

ELLIS W ADAMS MD 098
720 W FRANKLIN
JACKSON MICHIGAN 49201

FREDERICK M ADAMS MD 174
800 S ADAMS
BIRMINGHAM MI 48011

JAMES B ADAMS MD 154
110 W SUGNET
MIDLAND MI 48640

JAMES R ADAMS MD 222
39 SHADY HOLLOW DR A
DEARBORN MI 48124

URIAH M ADAMS MO 038

MARCELLUS MI 49067

VINCENT B ADAMS MD 222
19641 MACK AVE
GROSSE PTE MI 48236

ARTHUR ADAMSKI MD 222
19600 VAN DYKE
DETROIT MI 48234

ADELTO ADAN MD 154
3103 WASHINGTON
MIDLAND MI 48640

EARL R ADDISON MD 054
412 SUPERIOR AVE
CRYSTAL FALLS MICH 49920

IRWIN P ADELSON MD 222
1151 TAYLOR
DETROIT MI 48202

SEYMOUR S ADELSON MD 174
20305 GREENFIELD RD
SOUTHFIELD MI 48075

SIDNEY L ADELSON MD 222
16221 SCHOOLCRAFT
DETROIT MI 48227

EDWARD ADLER MD 174
WM BEAUMONT HOSP A
ROYAL OAK MI 48072

SIDNEY ADLER MD 222
3011 W GRAND BLVD L
DETROIT MI 48202

RAM ADVANI MD 106
1840 WEALTHY ST SE
GRAND RAPIDS MI 49506

MARTHA A AFTANAS MD 146
ST JOSEPH LLUYD HOSP
MENOMINEE MI 49858

MANOOCHEHR AGAH MD 222
6765 ORCHARD LAKE RD
ORCHARD LAKE MI 48033

VERINDER K AGGARWAL MD 222
3800 WOODWARD AVE #308
DETROIT MI 48201

NILS O AGNEBERG MD 146
531 1ST ST
MENOMINEE MI 49858

GEO F AGNEW MD 222
3011 W GRAND BLVD L
DETROIT MI 48202

ASIRUDDIN AHMAD MO 174
5885 M-15
CLARKSTON MI 48016

BUSHARAT AHMAD MD 134
1414 W FAIR AVE
MARQUETTE MI 49855

MANZOOR M AHMAD MO 178
601 E MAIN ST
HART MI 49420

ZAHEER G AHMAD MD 222
25210 GRAND RIVER
DETROIT MI 48240

J H AHRONHEIM MD 098
569 WILDWOOD AVE
JACKSON MICH 49201

DONALD J AIKEN MD 090
2243 W GRAND RIVER
OKEMOS MI 48864

MANUEL A AIRALA MD 034
1554 E MICHIGAN
ALBION MI 49224

MARTA S AIRALA MD 034
1554 E MICHIGAN
ALBION MI 49224

GEO T AITKEN MD 106
50 COLLEGE AVE SE
GRAND RAPIDS MI 49503

JAS J AIUTO MD 222
22311 MACK
ST CLAIR SHORES MI 48083

EDWARD P AJEMIAN MD 102
203 BRONSON MED CTR
KALAMAZOO MICH 49006

ISSA S AJLOUNI MD 222
2075 E 14 MILE RD
BIRMINGHAM MI 48008

ROGER M AJLUNI MD 222
17920 FARM RD
LIVONIA MI 48152

SYED S AKHTAR MD 190
1232 N MICHIGAN AVE
SAGINAW MI 48602

CECIL N AKROYD MD 222
16551 W WARREN
DETROIT MI 48228

EMIL J ALBAN JR MD 222
7940 ALLEN RD
ALLEN PARK MI 48101

A B ALBARRACIN MD 222
3360 CHARLEVOIX
DETROIT MI 48207

A P ALBARRAN MD 222
WAYNE CO GEN HOSP
ELOISE MICH 48132

G DONALD ALBERS MD 106
203 PARIS AVE SE
GRAND RAPIDS MI 49503

MILLARD J ALBERS MD 190
1227 N MICHIGAN AVE
SAGINAW MICH 48602

ROBERT ALBERS MD 186
601 MICHIGAN
HOLLAND MI 49423

DONALD G ALBERT MD 174
3535 W 13 MILE RD
ROYAL OAK MI 48072

ALBERT J ALBRECHT MO 222
15901 W NINE MILE RD
SOUTHFIELD MI 48075

ROBT W ALBRECHT MD 174
2111 CASS LAKE RD
KEEGO HARBOR MI 48033

ARNOLD A ALBRIGHT MD G34
15550 M-66 N
BATTLE CREEK MI 49017

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CARL R MOE MO 102
358 BRONSON MED CTR
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17544 MUIRLAND L
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EARL G MOEHN MO 126
309 MACOMB OAILY 8LOG
MT CLEMENS MI 48093

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JAN C MOELLER MO 062
3102 WESTWOOO PKY
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ELLI MOELLER-FABOK MO 114
602 S POTTAWATAMIE ST
TECUMSEH MI 49286

CURNETTA G MOEN MO 106
844 LEFFINGWELL RO NE L
GRANO RAPIOS MI 49506

WM J MOERDYK MO 186
120 W 14TH ST L
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1447 N HARRISON
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FLINT MI 48503

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26321 WOODWARO
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2959 CROOKS RO
TROY MI 48084

GLENN E MOHNEY MO 194
1131 ERIE ST
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879 MARYLANO NE A
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17526 CHESTER
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3827 GATE ORIVE
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JOS R MONTANTE MO 222
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16633 GOLFVIEW
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24646 LYNDON
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J F GIRARO ROOKS MO 026
2611 MORTON
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1339 PLAINFIELO NE
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ROBERT A ROONEY MO 174
667 KINGSLEY TRAIL
8LOOMFIELO HILLS MI 48013

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23077 GREENFIELO
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65 W HANCOCK L
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8620 W MC NICHOLS RO
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22339 LALOIRE
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17120 NEW JERSEY A
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6720 EDINBOROUGH
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15401 W MC NICHOLS
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6767 W OUTER OR
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SAUL ROSENZWEIG MO 222
2114 OAV BROO TOWER L
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GLENN A ROSIN MO 174
149 S CRNBK CROSS RO
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18215 GREENFIELO
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25323 BRIARWYKL OR
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1725 GLASTONBURY L
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28700 E EIGHT MILE RO
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18211 W 12 MILE RO
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ALEXANDER N ROTA MO 222
4363 SUNNINGDALE OR
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EOWARO M ROTARIUS MO 222
19939 ARTHUR APT 245 R
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19136 MENOOTA AVE
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15121 W SEVEN MILE RO
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WILLIAM J ROTH MO 074
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13419 FENKELL
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E N ROTTENBERG MO 222
20725 W SEVEN MILE RD
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LEON ROTTENBERG MO 222
13419 FENKELL AVE
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NORMAN J ROTTER MO 222
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601 MICHIGAN
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MSMS at Work . . . Serving Doctors, Public

Here is a description of the Michigan State Medical Society operations and efforts to serve both the doctors of medicine and the public. The material focuses on current activities to provide leadership in a changing local, state and national setting.

The Michigan State Medical Society serves some 8,200 doctors and the people of Michigan.

The Society conducts programs to advance the professional and economic affairs of its members and to provide specific personal services.

A House of Delegates, the governing body, represents the component societies of MSMS and decides policy positions.

Interaction with all phases of the medical profession is maintained through 80 permanent and ad hoc committees. A 10-member judicial commission, elected by MSMS membership, oversees ethical principles within the society.

MSMS programs include post-graduate medical education, legislative relations, socio-economics, etc.

Members receive a monthly journal, *Michigan Medicine,* and other pertinent publications.

The MSMS headquarters in East Lansing is a distinctive building designed by noted Michigan architect, Minoru Yamasaki.

The decisions of MSMS — the one organization representing the state's entire medical profession — influence the entire medical and health industry.

MSMS at work . . . . . developing policies on medicine and health

The procedure by which every MSMS member can participate in MSMS policy decisions has been refined over 108 years. It works like this:

1. Each MSMS member has a voice in establishing the policies of the State Medical Society, through the democratic process set up by the Society.

2. Each MSMS member elects delegates to the MSMS House of Delegates. Each member may ask his delegates to introduce a resolution before the House.

3. Delegates are elected by the 56 component county medical societies. Specialty sections and Student American Medical Association chapters at the three state medical schools are also represented.

4. Resolutions are submitted in writing to the House. Each is turned over to an appropriate reference committee, which holds open hearings at which any interested MSMS member may testify. Some resolutions are concentrated within the profession, but many concern both doctors and public. One resolution, for example, instructed a committee to investigate new incentives for attracting physicians to areas of acute need. Another offered the help of MSMS in programs of drug education.

5. After the hearings, the committee recommends approval, disapproval, or develops an amendment to the resolution. The report then goes to the House for action.

6. The members of the House act on the reports of each reference committee. Many points of view are presented. Sometimes a special committee is established to study the matter further and report alternatives to the next session.

7. The MSMS Council, which serves as a board of directors and meets regularly between annual sessions, is responsible for implementation of resolutions. The Council also introduces resolutions through the immediate past president. Such resolutions follow the same procedure as those submitted by individual delegates.

8. Each adopted resolution is assigned to the appropriate MSMS committees for implementation. The Speaker and The Council chairman submit a written report of the follow-through on each resolution.

MSMS at work . . . . . through its fine headquarters staff

The staff structure of MSMS was streamlined in 1970 after a major management study—and operates efficiently today through three departments and several adjunct units.

Warren F. Tryloff is the director, responsible for the operation of the 24-member staff and headquarters.

The Department of Government Relations is crucial to the interests of the physician. Two staff members maintain a constant liaison for physicians with state and federal legislators as well as with many government agencies. This department also supervises the work of the Bureau of Economic Information.

The Department of Communications and Professional Information informs members of Society activities and tells the public the doctors' side of the issue. News releases, a weekly radio program, meetings with various media people all are tools used to report and interpret MSMS policy and positions to the public. *Michigan Medicine,* the twice monthly *Medigram* and "Medical Memo" keep doctors posted.

The Department of Operations and Economics coordinates the House of Delegates sessions and oversees the daily operation of the building and several service departments. Other major activities deal with peer review systems and health care delivery.

The scientific coordinator handles the Annual Scientific Session, the MSMS continuing medical education programs and various workshops, and assists the many scientific committees.

A controller is in charge of accounting, maintains membership records and handles business operations.

MSMS at work . . . . . obtaining economic information for doctors

In order to respond to the increasing need of physicians for social and economic facts, the Bureau of Economic Information was established by a resolution of the 1970 House of Delegates.

Since then, the Bureau has sent MSMS members the results of several meaningful studies, including two overhead cost studies and two physicians' fee surveys. In addition, surveys on the availability of care, malpractice insurance, Medicaid and on other areas of interest have been conducted with good response from Michigan doctors.

The Bureau continues to expand its data bank by doing independent research. Resultant data from all MSMS research projects is made available to MSMS members and component medical societies and is used by various MSMS committees in their deliberations.

A development which has proved most helpful to doctors came about through the creation of a new format for the Michigan Relative Value Study. The code numbers of the Current Procedural Terminology, the National Association of Blue Shield plans and the old Michigan Blue Shield (Medicare) were matched, thus simplifying billing procedures. Section chairmen and specialty society leaders are involved in this and other projects of the Relative Value Study Committee.

MSMS works to keep physicians abreast of the developments in the Economic Stabilization Program.

Seven physicians serve as advisors to the Bureau in order to give the staff members guidance on projects.

MSMS at work . . . . . studying, influencing medical care legislation

Efforts of the MSMS to protect and improve medical care in Michigan are as old as the Society itself. Starting immediately after the Civil War, members worked for three years to convince the

Legislature to establish a State Board of Health.

Today the Society works through a full-time staff person and committees on state and federal legislation to keep informed about legislation which can affect the medical profession.

The MSMS legislative efforts are based on resolutions adopted by the House of Delegates, directions from The Council and committee advice. MSMS provides expert testimony before various legislative committees on many medical issues.

Besides maintaining daily contact with the legislature, the Department of Government Relations provides staff and counsel for three exciting new programs:

Volunteer Lobbying Program utilizes the talents of individual physicians in lobbying efforts. The physician arrives at the MSMS offices for a briefing on pending legislation. He spends the rest of the week at the Capitol. Reaction is excellent from both doctors and legislators, and other states are following Michigan's lead in this innovation.

Component societies' meetings with legislators "back home" provide continuing contact between legislators and the physicians in their constituencies. Several component societies, with MSMS support and advice, hold regular sessions with their own legislators in the legislators' home districts. MSMS offers guidance and direction to any component society willing to implement such meetings.

MDPAC (Michigan Doctors Political Action Committee) is a separate voluntary non-profit group of physicians, their wives and other interested persons. MDPAC's primary function is to support political candidates in behalf of organized medicine. In addition, it works to keep doctors informed of medical-political issues and gives them an avenue for concerted political action. MDPAC offers voting records and other information to members, studies candidates on the basis of those who support or will support medicine's position. It coordinates its efforts with other groups engaged in working for better government. It is guided by a 30-member board of directors.

MSMS at work . . . . . with state and federal agencies

More and more medical and health programs are being affected by government agencies. It is only through organized medical groups that physicians can present a united front to legislative and governmental questions. MSMS remains alert to these questions. Every Michigan doctor is affected by MSMS efforts to understand and influence government programs, regulations and proposals.

A MSMS staff specialist on government medical care programs keeps the appropriate MSMS committees informed about the numerous proposed and operative government-funded programs which provide medical care to citizens.

The Department of Government Relations provides information to The Council via the Committee on Federal Legislation and other related committees.

For example, the Medicaid Liaison Committee, established pursuant to House of Delegates action, meets on a regular basis with policy making personnel of the Department of Social Services. Agenda material for these meetings ranges from basic policy to individual complaints of practicing physicians.

In addition, important liaison is maintained with the Michigan State Pharmaceutical Association, the State Board of Registration in Medicine, the Michigan Chapter of Health Insurance Council and the State Bar of Michigan. MSMS also has ongoing liaison with the State Office of Health and Medical Affairs, Department of Public Health, Department of Mental Health, drug abuse office, Office for the Aging and others.

The MSMS staff provides a volume of constantly changing information about government which could have profound effects on the physician's practice.

MSMS at work . . . . . with legal opinions for medicine

MSMS seeks to legally protect and advance the medical profession through a powerful trio: the staff-manned Department of Government Relations, the physician-oriented Legal Affairs Committee and a legal counsel.

Together they cover the broad area of evaluating and suggesting state legislation and protecting the professional welfare of physician members.

The legal counsel and the legislative affairs manager work in concert to check through the hun-

dreds of prospective statutes submitted each year to the Michigan legislature. Bills that need the professional expertise of legal counsel are sent to his Detroit office where he may analyze and/or write possible amendments as needed, in cooperation with MSMS staff members.

The counsel receives a large number of queries for legal advice from individual members and component societies and from hospital administrators. After researching previous court decisions, or studying the request, he answers each letter, with a carbon that goes into the files at MSMS. Thus, an extensive law-oriented view of medical problems over the past 20 years has been collected through this MSMS service.

Counsel points out that the most prolific inquiry sources are the MSMS Legal Affairs Committee, whose meetings he attends, and the doctors and hospital administrators in the smaller communities. However, he is available to answer as many inquiries as possible from physician members and societies.

Queries cover every conceivable health topic including: emergency room procedures, physician assistant problems, drug clinics, component society bylaws problems and others.

MSMS at work . . .
. . . providing continuing medical education

MSMS offers postgraduate medical education opportunities to members through a series of projects reaching every Michigan doctor.

After a special Task Force's report to the 1972 session, the House of Delegates voted to establish a Commission on Continuing Medical Education. This body will develop a flexible series of standards of continuing education for physicians practicing in Michigan.

The fall Scientific Session, held annually for more than a century, features a two-day series of lectures, panels and demonstrations to cover the interests of every medical specialty. The selection of speakers and pertinent topics begins one year before the scheduled dates. Work is coordinated by both physician members and staff personnel through the MSMS Division of Scientific Affairs.

The monthly MSMS journal, *Michigan Medicine,* includes a wide selection of carefully chosen scientific articles selected by a physician-scientific editor. It also carries short articles about MSMS activities and projects.

Special conferences, such as those on Maternal and Perinatal Health and the Medical Aspects of High School Sports, draw a large number of interested physicians.

MSMS at work . . .
. . . communicating with public and profession

The Department of Communications and Professional Information keeps MSMS members informed of activities within the society. It also seeks to make the public aware of progressive medical thinking through the news media, conferences, etc.

All new members receive a certificate of membership . . . MSMS members receive *Michigan Medicine,* a monthly publication which carries current medical articles and columns by MSMS staff . . . *Medigram,* a capsulized two-page news sheet, is also mailed twice each month to members to inform them of late-breaking medical news. Each week a sheaf of newspaper clippings about medical news is sent to various Michigan leaders in the health professions.

The new MSMS "Medical Memo" is a toll-free telephone news report designed to keep physicians up to date on medical events and issues. MSMS updates the message weekly or more frequently as events dictate.

The Department also services the news media. News releases are sent regularly to 50 dailies and 300 weeklies. News writers call almost daily to obtain background information and news sources for feature stories.

Aware of the need to keep news media updated, MSMS sponsors an annual Medical Writers Conference for Michigan science and free-lance writers. News conferences are called periodically to give the MSMS viewpoint on current topics. Recent meetings dealt with the physician assistant program, efforts to decrease infant mortality, and positive suggestions for handling Medicaid payments.

A weekly radio program, "Prescription for Health," sponsored by MSMS, is produced by station WUOM, in Ann Arbor and sent to many Michigan stations.

The Department provides liaison with many groups and leaders from such fields as education, youth service, health agencies, community groups, etc.

MSMS at work . . . . . . helping to place new doctors in Michigan

At the recommendation of the House of Delegates in its 1973 Spring session and the Committee on Planning and Priorities, MSMS is cooperating with the Michigan Health Council in its efforts to place physicians in Michigan. By combining resources, MSMS and MHC improve an already effective recruitment and placement program. The goal is to equalize the distribution of physicians throughout the state so all citizens are provided professional medical care.

MSMS at work . . . . . . cooperating with component societies and specialty groups

MSMS maintains liaison with Michigan's 56 component county societies. Efforts to encourage and strengthen these contacts are continuous:

1) Staff members attend county medical society meetings, upon request, to initiate personal contact with officers and members. They present the latest information about MSMS activities and solicit comments of members.

2) The MSMS councilors invite county officers to annual councilor conferences. Delegates, county officers and executive secretaries are able to gain better understanding of the work of their district councilor and The Council as a body.

3) MSMS sponsors Leadership Conferences for leaders of components and specialty societies and regularly sends important reports, notices and publications for their information and consideration.

4) During the past several years, MSMS has worked closer than ever before with the specialty sections and specialty societies. MSMS was instrumental in the formation of the Council of Medical Specialties which meet regularly at the MSMS headquarters and utilizes MSMS staff specialists for advice and guidance.

MSMS at work . . . . . . in the AMA

The House of Delegates elects delegates from MSMS membership to the AMA House of Delegates, its policy-making body, to two year terms. MSMS delegates introduce resolutions, present Michigan testimony at reference committees and actively participate in floor debates.

In addition, delegates serve as liaison between AMA and component societies and local membership, appearing as speakers before County Medical Society meetings and occasionally holding hearings in the state on issues of national importance.

Due to the proximity of AMA national headquarters in Chicago, AMA executive staff members frequently participate in MSMS conferences and meetings.

MSMS members are frequently elected to important policy-developing AMA councils and commissions.

MSMS at work . . . . . . providing increasing member benefits

The varied package of member benefits includes group insurance opportunities, vacation trips and an automobile leasing service.

The group insurance opportunities prove that membership in MSMS provides real dollar savings and vital protection.

Six group insurance plans are available to MSMS members. They include:

1. Professional overhead coverage.
2. Michigan Blue Cross-Blue Shield for hospital and medical-surgical care.
3. A disability-sickness policy.
4. Group life.
5. Accidental death and dismemberment.
6. An umbrella-type supplementary "Personal Prestige Policy."

More than 50% of MSMS members are enrolled in at least one of the plans, at a group rate which offers considerable savings. The Society mails to each new member a series of descriptive brochures concerning group plans available. The Ben P. Stratton Agency, Lansing, is responsible for premium collection and handling of all claims.

In order to participate, a doctor must be a member of MSMS through his county medical society. Interns and residents enrolled as associate members in MSMS are also eligible for any policy.

MSMS sponsors three vacation trips each year, combined with medical seminars, for members and their families to various parts of the world. Lectures, discussions and visits to medical facilities presented by leading experts in various fields provide the opportunity to broaden experience and gain a perspective on medicine as practiced in other cultures.

Another benefit through MSMS is an automobile leasing program. Leasing offers substantial tax advantages along with time saving convenience. Members may choose the automobile they wish to rent from a brochure containing rates and details on optional features from the New Car Leasing Program of McCullagh Leasing, Inc. MSMS members receive the same low rate as large fleet users through this exclusive plan.

MSMS at work . . . . . with medical students, SAMA chapters

The Michigan SAMA officers attending the 1970 Annual Session requested that SAMA representatives be given official voting privileges. Frankly stating that many medical students viewed organized medicine with distrust, the spokesman stated: "To our surprise, we found here a vital, responsive, democratic group actively endeavoring to better the practice and availability of medical care in the state."

MSMS believes that students' enthusiasm and fresh viewpoints strengthen the medical profession. Accordingly, the delegates concurred and the three Michigan medical schools seated voting delegates for the first time.

Students also participate on committees of special interest to them, such as drug dependence, rural health, public relations, maternal welfare. SAMA officers periodically report their activities to MSMS and are asked by *Michigan Medicine* to express their views on contemporary medical issues.

For many years, MSMS has given financial grants to the Student American Medical Association chapters in Michigan for programs and conferences. A new MSMS liaison committee of interested doctors and students is set up to hear student concerns and needs.

Working closely with SAMA and the Michigan Hospital Association, MSMS has coordinated a program whereby students serve during the summer in community hospitals. Participants, who have completed their freshman year in medical school, serve under a doctor-preceptor and receive a stipend from the hospital.

Legislative efforts to assist medical schools and students continue, of course, in the MSMS department of legislative affairs.

MSMS at work . . . . . for more than a century of service

In 1819, the five Detroit physicians practicing in Detroit organized the "Michigan Medical Society" under Territorial laws. Since there were only five members and seven offices, some held two offices.

This society, dedicated to insuring a "clean, well-educated, honest profession in Michigan," was limited largely to observing state medical laws. It was not until June 5, 1866, that about 100 physicians met in Detroit to hear Morse Stewart, MD, claim that "The profession had failed to promote properly the advancement of medical, individual growth and development . . ." As a result the present MSMS was officially founded.

Many members of the new organization were involved in the push to establish a State Board of Health, which was inaugurated in 1873. During the remainder of the century, members grew in scientific knowledge. Physicians were urged to observe

the AMA code of ethics, and articles were published in the *Peninsular Journal.* County societies were formed and in 1902, after 17 years of discussion and debate, the organization approved a House of Delegates pattern.

The next 15 years was a time of active growth. The meetings of 1915 to 1920 sound curiously contemporary: Delegates heard about the increase of syphilis and gonorrhea, the rising printing costs of the *Journal,* and the need to be "alert and watchful" in the face of spreading government programs in health care.

The 1930's, although reflecting the effects of the depression, was a decade of great service to members and the public. On Aug. 20, 1931, with a polio epidemic threatening, the MSMS sent an immediate bulletin to all members describing the tell-tale symptoms. Physicians operated on thousands of people under the Afflicted and Crippled Children's program, and their no-fee policy saved the state of Michigan over 3 million dollars. MSMS began working with state health agencies to reduce infant and maternal mortality rates. A doctor placement service was initiated and the House of Delegates approved the group medical-surgical care plan which became Michigan Blue Shield-Blue Cross.

In the 1940's, of course, the important matters were the war and defense efforts. By 1943-44 more than 2,100 Michigan doctors were in the Armed Forces. However, ideas continued to be implemented by MSMS. In 1944 the Michigan Health Council was incorporated, and the following year the Michigan Foundation for Medical and Health Education was born. The first statewide Rural Health Conference was held, and the first Michigan Cancer Conference.

The 1950's ended with the ground breaking of the new MSMS headquarters on Abbott Road, East Lansing. With the heightened post-war emphasis on communications, MSMS continued to work for the profession through publications, radio and television programs, and motion pictures.

In 1961 the MSMS moved to its new quarters to improve services to members and the public. The Centennial Year of the Society was celebrated in 1965 in Detroit. Activities have been modified so committees of the House of Delegates and the Society now study current medical and social issues and recommend action designed to serve the people of Michigan.

Specific questions about MSMS member benefits or services to the public may be addressed to:

Warren F. Tryloff, Director, Michigan State Medical Society, 120 W. Saginaw St. East Lansing, MI 48823

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Addresses for Agencies and Associations, in The Medical Field:

Organizations

Michigan State Medical Society
(Phone: 517/337-1351)
120 W. Saginaw St., East Lansing, MI 48823

American Medical Association (312/751-6000)
Headquarters: 535 N. Dearborn St., Chicago 60610
Washington Office: 1776 K St., Washington, D. C. 20006

Michigan Association for Regional Medical Programs (Phone: 517/351-0290)
1111 Michigan Ave., East Lansing, MI 48823

Michigan Doctors Political Action Committee
P.O. Box 769, East Lansing, MI 48823

Michigan Foundation for Medical and Health Education (Phone: 517/337-1351)
120 W. Saginaw St., East Lansing, MI 48823

Michigan Health Council (Phone: 517/ED7-1615)
712 Abbott Rd., East Lansing, MI 48823

Michigan Hospital Association
(Phone: 517/484-8415)
2213 E. Grand River, Lansing, MI 48913

Michigan Hospital Service (Blue Cross)
(313/225-9652)

Michigan Medical Service (Blue Shield)
(313/225-9000)
600 Lafayette East, Detroit, MI 48226

State of Michigan

Office of Health and Medical Affairs, Lewis Cass Bldg., Lansing, MI 48913
Donald C. Smith, MD, Director
(Phone 517/373-7688)

Medical Practice Board, 1033 S. Washington, Lansing, MI 38933
John R. Wellman, MD, Secretary
(Phone: 517/373-0680)

Department of Mental Health, Lewis Cass Bldg., Lansing, MI 48913
E. Gordon Yudashkin, MD, Director
(Phone: 517/373-3500)

Department of Public Health, 3500 N. Logan, Lansing, MI 48906
Maurice S. Reizen, MD, Director
(Phone: 517/373-1320)

Department of Social Service, Commerce Center Bldg., Lansing, MI 48913
R. Bernard Houston, Director
(Phone: 517/373-2000)

Medical Schools

University of Michigan
Medical School
Ann Arbor, MI 48104
Dean: John Gronvall, MD, (Phone: 313/764-8173)

Wayne State University
School of Medicine
Detroit, MI 48201
Dean: Robert Coye, MD, (Phone: 313/577-1335)

Michigan State University
College of Human Medicine
East Lansing, MI 48824
Dean: Andrew Hunt, MD, (Phone: 517/353-1733)

Who to Call at MSMS Headquarters

The following staff members serve committees and/or are designated as staff specialists in the following fields.

Address all mail to MSMS, Box 950, East Lansing 48823, Phone: 517/337-1351.

AMA—Warren Tryloff
Articles for *Michigan Medicine*—Jeanne Smith
Automobile Lease Plan—Richard Campau
Doctor-of-the-Week Legislative Project—Sherry Hall
Dues Payments—Robert Roney
Government Medical Care Programs—Bruce Ambrose
Health Career Recruitment—Mert Scholten
HMO (Health Maintenance Organization)—Herbert Mehler
Judicial Commission—Vada Davis
Legislation—Bruce Ambrose
Malpractice—Bruce Ambrose
MDPAC—Sherry Hall
"Medical Memo" taped news service—Jeanne Smith
Medical School & Medical Student Relationships—Herbert Auer
MSMS Annual Scientific Session—Helen Schulte
MSMS Group Tours—Helen Schulte
MSMS House of Delegates Meeting—Richard Campau
MSMS Membership—Robert Roney or Herbert Auer
MSMS Sponsored Insurance Programs—Robert Roney
News Media Relations—Mert Scholten
Physician Assistant—Herbert Auer or Mert Scholten
Peer Review—Richard Campau
Physician Placement—Herbert Mehler
Questions about Chiropractic—Herbert Auer
Relationships with Osteopaths—Bruce Ambrose
RVS—John Anthony
SAMA-MECO Project—Jeanne Smith
Socio-Economic Surveys—John Anthony

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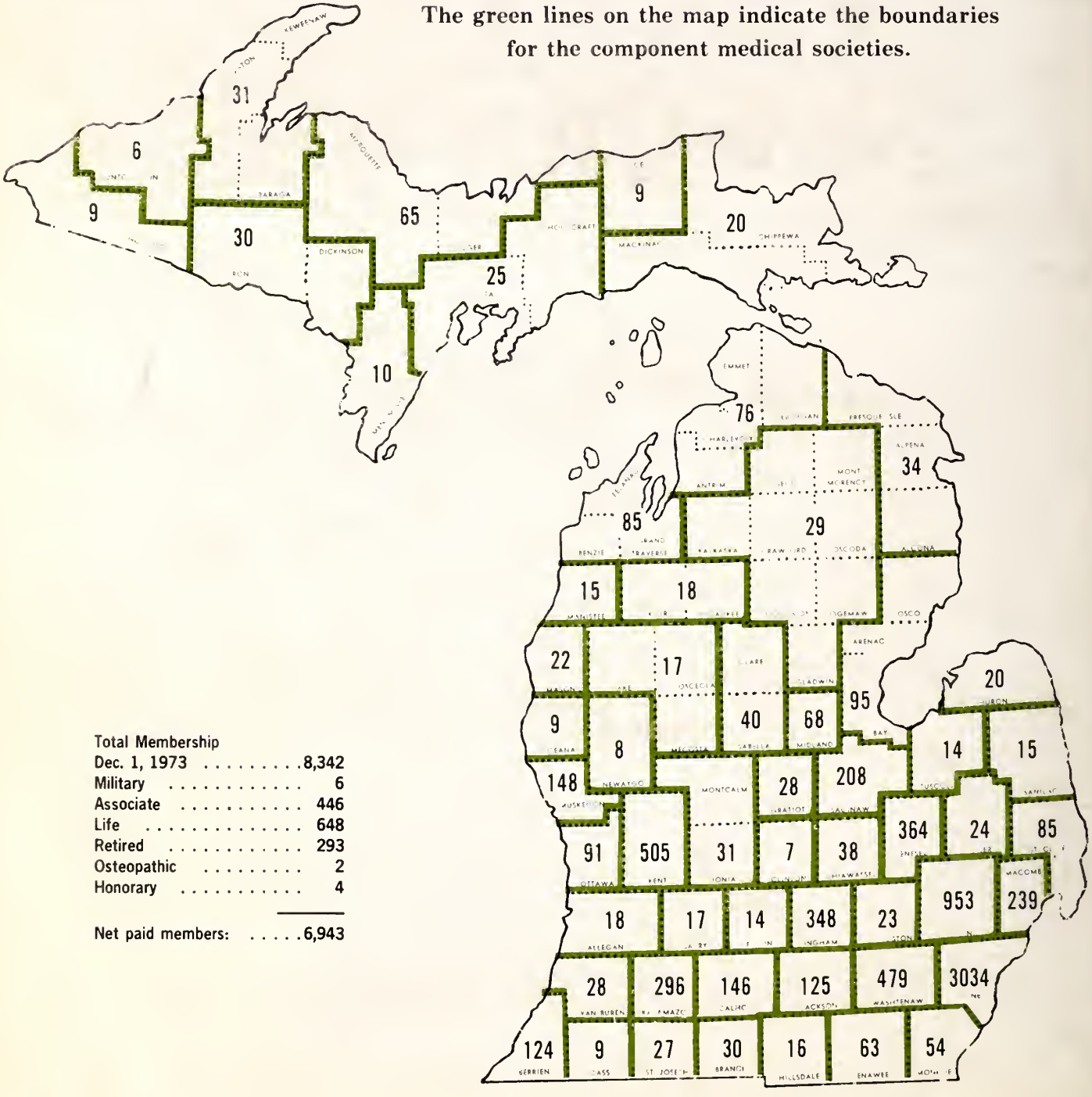
Directory of MSMS Members

The green lines on the map indicate the boundaries for the component medical societies.



Total Membership	
Dec. 1, 1973	8,342
Military	6
Associate	446
Life	648
Retired	293
Osteopathic	2
Honorary	4
Net paid members:	6,943

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) *Capsules*, 5 mg, 10 mg and 25 mg —bottles of 100 and 500; Tel-E-Dose® packages of 1000. Libritabs® (chlordiazepoxide) *Tablets*, 5 mg, 10 mg and 25 mg —bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

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Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

to help reduce clinically significant anxiety and thereby help improve patient receptivity

Librium® up to 100 mg daily in severe anxiety

(chlordiazepoxide HCl)

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Symptom of excessive anxiety:

The patient may have difficulty in accepting medical counsel.

Clinical experience has shown that some unduly anxious patients may tend to deny or minimize their illness and therefore resist seeking or following medical advice. Through its antianxiety action, adjunctive Librium (chlordiazepoxide HCl) can often calm the emotionally tense patient, thereby encouraging physician-patient rapport and, on occasion, making it easier for the patient to accept medical counsel.

for relief of excessive anxiety

ROCHE **Librium® 10-mg capsules**
(chlordiazepoxide HCl)

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MICHIGAN/MEDICINE

OFFICIAL JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY

VOLUME 73, NUMBER 36 DECEMBER, 1974

Both often

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

The Bactrim™ edge

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

A high assurance of clinical efficacy

- in cystitis, pyelonephritis and pyelitis diagnosed as chronic
- against susceptible strains of the common urinary tract pathogens, usually *E. coli, Klebsiella-Enterobacter, Proteus mirabilis,* and, less frequently, indole-positive proteus species.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Enterobacter, Proteus mirabilis,* and, less frequently, indole-positive proteus species).

Note: The increasing frequency of resistant organisms limits the usefulness of antibacterials, especially in chronic and recurrent urinary tract infections.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia in elderly patients on diuretics, primarily thiazides. Sore throat, fever, pallor or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted. Data are insufficient to recommend use in infants and children under 12.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, allergy or bronchial asthma; and in those with glucose-6-phosphate dehydrogenase deficiency, where hemolysis may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for children under 12.

Usual adult dosage: Two tablets b.i.d. for 10 to 14 days. For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	2 tablets every 24 hours
Below 15	Use not recommended

Supplied: Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 1000; Prescription Paks of 40, available singly and in trays of 10.

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Division of Hoffmann-La Roche Inc.
Nutley New Jersey 07110

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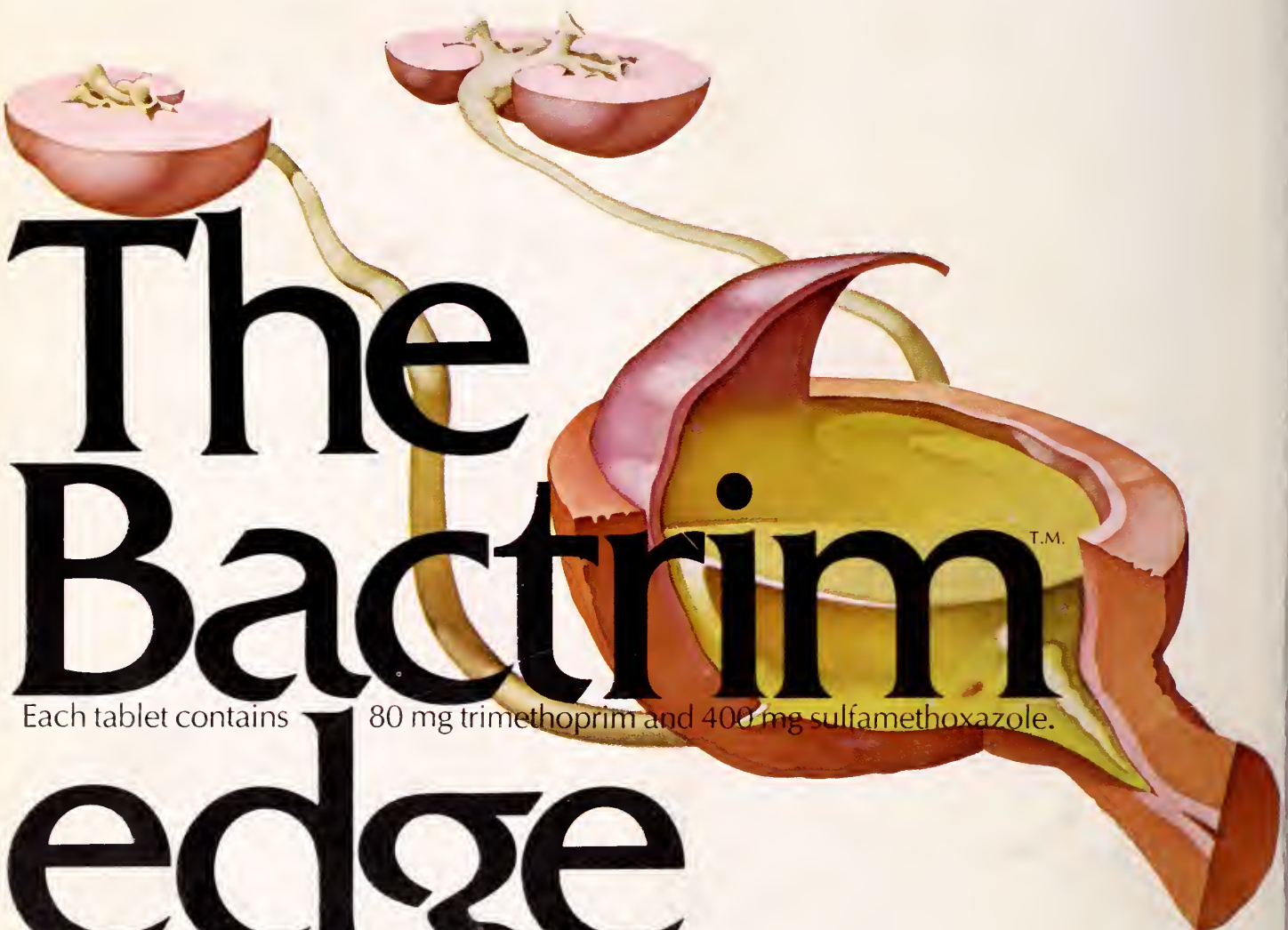

The Bactrim™ edge

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

A high assurance of antibacterial activity in cystitis, pyelonephritis and pyelitis diagnosed as chronic and due to susceptible organisms.

Before prescribing, please consult complete product information, a summary of which appears on preceding page.

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